# Orientation to Partnership Washington State

## Board of Health-Department of Health

September 18, 2006

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# Section 1: Introduction

## Purpose of the Department-Board Collaboration and of this Orientation

September 1, 2006

Thank you for attending this orientation to partnership between the State Board of Health and the State Department of Health. Our individual and collective mission of improving and sustaining the health of all citizens in the State of Washington will be well served by your participation.

As Chair of the Board and Secretary of the department, we know our best work occurs through collaboration. Effective public policy is developed by the department staff and board staff, informed through stakeholder involvement, formally adopted by the citizen board and administered through the department's divisions and programs. The board and department's roles differ and neither is more important than the other.

This orientation program has been developed through the assistance of the Board and its staff and by the department's Office of the Secretary, regulatory affairs manager, assistant secretaries, office directors and division liaisons. The preponderance of our interactions are productive and effective already. Our intention in sponsoring this program is to increase our understanding of the partnership and bolster relationships throughout the board, its staff, and the entire department.

Thank you again for taking the time to help us further develop our partnership.

Secretary of Health, Mary Selecky
Board Chair, Dr. Kim Marie Thorburn

## Quick Tips

If you are already engaged in a policy or rule development project, consider jumping to Section 6 - Rapid Huddles. If you are not familiar with policy and rule development or with the partnership between the department and the board and you are in a rush, apply the following and then come back to the complete orientation as soon as you can.

**Rule number 1:** Collaboration is essential for good public policy.

**Rule number 2:** Collaboration is not about agreeing on everything.

**Rule number 3:** Collaboration requires a lot of conversation.

**Rule number 4:** Repeat number 3 until done.

To initiate a working partnership and get your project off to a good start:

1. Find out were statutory authority resides and clearly identify the scope of that authority for this topic.
2. List all the people involved in the project in the department and the board.
3. Talk to them and find out who is missing from your list.
4. Get agreement from the senior most person you can find to call a meeting.
5. Meet and compare objectives and scope for the project **AS SOON AS POSSIBLE.**
6. Take a moment and discuss the perspectives of each person in the room:
    a. What is the significance of this issue for you / your agency or division.
    b. What are the major challenges?
    c. What would help?
    d. Who needs to be involved?
    e. What do we know about the history of this issue?
    f. Anything else?
7. Identify the anticipated contributions or role of each person.
8. Agree to a meeting schedule for quick progress checks.
9. Read this resource book for more details and the subtleties of the policy partnership between the board and the department.

## Preface

**Origin and objective of this document:** The Secretary of the Department of Health and the Chair of the State Board of Health have determined that well informed staff members with effective working relationships are vital to these two distinct and interdependent government agencies. On December 4, 2004, these leaders agreed to initiate a project that would: generate broad understanding of the agencies' respective missions, clarify roles, facilitate improvement in relationships and create an orientation process for building long-term partnerships.

Small differences in processes, politically charged situations, divergent stakeholder interests and science vs. policy dilemmas create an environment ripe for misunderstandings in relationships between department and board staff. Staff members at all levels have an on-going and difficult task in managing the interactions among people who develop and decide upon new policies.

The challenge for the staff and board members, is to have the understanding of processes and issues and the spirit of collaboration necessary to get their jobs done No one in the department or board wants to make work difficult, but even the best-intentioned person can generate misunderstandings that lead to extra work and conflict. The best strategy is to build in the discipline and time needed to maintain working partnerships. As skills increase, collaboration takes less time.

If collaboration seems to take a lot of time, consider the costs of not maintaining the partnership. Some of these costs are:

1. Decision and policy makers miss information to make good decisions.
2. The reactive political environment amplifies miscommunication and mixed messages.
3. Misunderstandings and unaligned actions bog down already lengthy processes.
4. Duplication and corrections consume scarce staff and board member time.
5. Stakeholders conclude the "state" is inefficient and disorganized.
6. Personal relationships or trust are harmed, making future interactions more tenuous or cautious.

**Facilitator Tip:**

Ask the participants to talk about their own experiences by asking these questions:

What are examples of times when a partnership across agencies or departments worked very smoothly? What helped it work well?

Think of an example of a partnership that did not go well. What might have helped in terms of increased understanding, role clarification, improved information or other aspect of good collaboration?

This resource book explains the complexity you will face in your public health work, regardless of whether you are a new scientist, office manager, program director, assistant secretary, board member or even a new department secretary or board chair. And it will offer methods for managing that complexity.

## Overview of Policy Authorities

The mission of the State Board of Health is to provide statewide leadership in advancing policies and activities that protect and improve the public's health. The mission of the Department of Health is to work to protect and improve the health of the people in Washington State.

To a newcomer, these missions might suggest that the two state agencies do the same work. However, there are important and often subtle differences in the activities, sources of authorization for policy development and procedures for making or renewing policies.

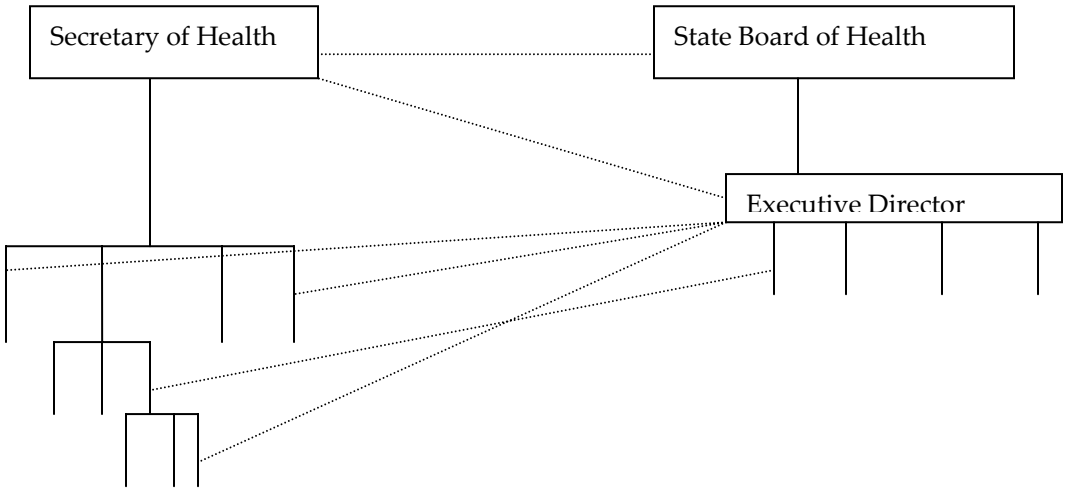
Perhaps the most important point to be made in this guide is that neither agency can fulfill its mission independently. Nor does it help the public or other state entities for the agencies' staffs to be in conflict.
The public policy development relationship between Department of Health and State Board of Health is complex. Some of the factors that generate complexity are:

- Both agencies are passionate and each has its own sense of priorities.
- Decisions must be made in a public environment.
- Success depends on two distinct entities that necessarily rely upon each other but each has its own policy responsibility and technical expertise.
- The board relies on the department for administration and implementation of many of its policies.
- The department relies on the board to establish policy within the department's resource constraints.
- There are many other entities that sometimes apply pressure differently to the two agencies.
- The work depends on trust, personalities, communication skill, procedural knowledge, issue knowledge and relationships among many people at many levels.
- Procedures for making new rules are specified by law and contain many steps.
- The agencies derive their original authority from different sources (governor for the department / the State Constitution for the board).

# Section 2: General Orientation

## Complexity in policy making

Three major factors create a complex maze of issues and relationships in public health policy development. The first is the differences in organization size and structure as illustrated below. The board and its entire staff total 18 people and can easily hold a meeting in one conference room. The department has 1,300 employees and many levels of program and management. Each of its divisions has distinct responsibilities, expertise and even organization culture.




Second, each policy topic requires interaction between the executive director or other board staff and people at many levels within the department as shown in the dotted lines above. These are not "reporting relationships" but contact points necessary to do the combined work of the board and department done. These contact points are determined by status of a project (beginning, middle, end), the topic, testimony/ public comment, the political heat of an issue and the people involved from other organizations beyond the department and the board.

This network of relationships requires keeping the rest of the system informed. If contact is between a board staff member and a program subject matter expert, who keeps the rest of the organization up to date? A skillful liaison for the entire organization and liaisons for each division help manage information. Not everyone keeps the liaisons up to date, however, so their awareness may be incomplete. Note also that each division of the Department of Health has slightly different liaison policies.

The dynamics of state government add a third major factor of complexity. For example, in a politically charged environment, surprises generally spell trouble. If the Secretary, the Board Chair, and the Executive Director, for example, unexpectedly give vastly different recommendations to a legislative committee, it can create real problems and personal embarrassment. Even being informed of the different views helps manage in the political environment. Coordinated recommendations, when they can occur, are far better.

The dynamic environment of government also creates multiple roles for senior level administrators. The Secretary, for example, is the head of a large agency, a member of the governor's cabinet, legislative leader as agency head, Board of Health member and member of the Senior Management Team. Each role may involve different relationships, responsibilities, and authority.

Other potentially troubling issues in the rapidly moving environment include: lack of policy rigor, lack of scientific rigor, lack of financial implication knowledge, usurping another authority's prerogative, and creation of policies that cannot be implemented.

How can this complexity be managed in a useful way? While some defined procedures and protocols help, there will be times when specific actions have to be based on principles rather than established methods. Some helpful principles for board-department policy development are:

Keep the right people informed
Make good, well thought out decisions consistent with overall intentions
Understand the implications of decisions or actions
Understand the resources needed to act on a decision
Make sure the plan can be implemented before adopting
Create needed agreements with the right people at the right time.

Managing complexity is also easier if you are aware of the magnitude of follow-up changes that a new policy implies. Examples could include:

Wording or procedural changes that need to be updated without changes in the effect or administration of the policy.

Changes in a policy that imply new approaches, methods, extent or authority.

Major new policy that requires new methods, statutes, legislation, implementation, acceptance.

By understanding the degree of change involved, all parties can assess the impact on their workloads and the necessary extent of involvement by interested parties. Remember, however, that even when there are precise methods and procedures, there is no substitute for talking with one another.

## History of Public Health Policy Development in Washington State

While the focus of this orientation is the partnership between the State Board of Health and the State Department of Health, it helps to explore their relationship in the context of all the major public health partners in the state. Each has a different function and source of authority embedded in its respective origins and history.

*Washington State Board of Health:* The 10-member Board of Health provides a citizen forum for the development of public health policy. It recommends strategies and promotes health goals to the Legislature and regulates a number of health activities, including drinking water, immunizations, and food handling. The board is physically housed in Department of Health facilities although it is an independent entity. The board derives its original constitutional authority from the Washington State Constitution.

*Washington State Department of Health:* The Department of Health was formed in 1989 to promote and protect public health, monitor health care costs, maintain standards for quality health care delivery, and plan activities related to the health of Washington citizens. The Secretary of Health is appointed by the governor. The statutory authority for the Department of Health is in the Revised Code of Washington 43.70.020.

*Local Health Departments/Districts:* Washington has 35 local health departments/districts. They are local government agencies, not satellite offices of the state Department of Health or the State Board of Health. Local health departments carry out a wide variety of programs to promote health, help prevent disease and build healthy communities. These districts serve 39 counties.

*Public Health Partners:* The Department of Health works with many health partners including the University of Washington School of Public Health and Community Medicine; American Indian Tribes and urban Indian health programs; hospitals and clinics; state and local community-based organizations, associations and coalitions. It also has close working relationships with federal agencies including the Centers for Disease Control and Prevention, the Department of Health and Human Services, the Department of Agriculture, and the National Institutes of Health. The Board of Health often works with the same partners.

*Additional background on the board and the department:* The unique history of the State Board of Health also provides a window into the policy environment surrounding public health administration in our state. The board dates back to the adoption of the State Constitution in 1889. Although the Board of Health is the state's only

constitutionally mandated board, Washington—from the beginning a populist state wary of centralized government authority—has traditionally relied heavily on citizen boards and commissions. Over time, executive branch agencies that report directly to the Governor have grown up around these bodies. Hundreds, however, survive today. Some are viewed as throwbacks to an old way of doing business, but the Board of Health has evolved to fill a distinct niche. Because of the highly collaborative nature of state's public health system, the Board of Health is as relevant today as it was more than a century ago.

Originally, Board of Health members were usually physicians selected for their medical expertise. They had authority over nearly all health-related rules in this state, including professional practices and hospital regulation. In 1984, the Legislature reconfigured the board. It reassigned regulatory activities to executive agencies, primarily the Department of Social and Health services, which at the time included the Division of Public Health. The reconfigured board kept activities regulated by the state but implemented jointly or exclusively by local public health.

These activities include most of the traditional functions of public health, such as septic systems, basic sanitation, drinking water and food safety, and communicable disease control.

In short, the Legislature created a nexus for shared policy making. The Department of Health is represented on the board by the secretary or a designee. Local health jurisdictions are represented by a local health officer. The cities and counties are represented by an elected official. There are also two slots to represent consumers—the public in public health. One health and sanitation member represents the tribes. Finally, four members represent health and sanitation, assuring that the board still has access to the expertise it needs to make sound decisions.

Taking a proposed rule or policy to the board also adds value because it provides consideration by board members who represent other public health partners and bring other points of view. The board is not the creature of a single agency, and represents all the partners, including the public.  It has a little more latitude to act as a bully pulpit-to speak its conscience on complicated and politicized issues. It also is seen at times as a neutral venue where people outside state government can air their opinions and expect to be heard.

The State Department of Health was created by the legislature in 1989 to place cabinet-level emphasis on those governmental services that protect and promote the public's health. The services were drawn from other agencies, where they had co-existed with other non-health related efforts. This was, in some ways, a return to a structure that had existed much earlier in state government, before the development of very large agencies such as the Department of Social and Health Services (DSHS).

**Facilitator Tip for Board Orientation:**

Refer to Appendix B, Department of Health Responsibilities to see the department's full scope.

The department has primary responsibility to assure:

- Safe, high-quality health care services
- Healthy, well-informed parents and healthy children
- Protection from the spread of communicable diseases
- Safe shellfish and food sold and served in Washington.
- Safe places to work and live
- Emergency preparedness and response
- Safe, reliable drinking water
- Chronic disease prevention and health promotion
- Effective Public Health Laboratories
- A strong public health network

## Emergency Preparedness—Partnership in Action

Department staff and board members often have clearly identified roles and operate in established frameworks. In these cases, the department and the board make very good partners. The relatively recent example of Emergency Preparedness is one such case.

Public health emergency preparedness is one of the Department of Health's top priorities. Since September 11, 2001, public health's role in emergency preparedness has greatly expanded. The department, along with our local health partners, would be on the front lines should the state face a bioterrorism event, radiation emergency or natural disaster that affects the public's health.

Public health emergencies demand a fast, competent and organized response. In this state, the Department of Health is part of a chain of response that also includes local health jurisdictions and the governor. The roles and responsibilities of the emergency response partners are described below.

**Local Health Jurisdictions**

1. Local Health Officers and Local Boards of Health
    - Prevent, control, and mitigate threats to public health
    - Control and prevent the spread of dangerous contagious or infectious diseases
    - Inform the public as to the causes, nature and prevention of disease and the preservation, promotion and improvement of health
    - Take such measures necessary to promote public health
    - Determine appropriate action for instituting disease prevention and infection control, isolation, detention, and quarantine measures to prevent the spread of communicable disease

    Physicians are required by law to report dangerous, contagious or infectious diseases to local health officers or the Department of Health within specified periods of time. Determining whether a person has a dangerous, contagious or infectious disease is solely within the authority of the local health officer until the state Department of Health is notified. The department's executive officer or representative then makes the final determination.

2. Local Emergency Operations Centers

   Local emergency operations centers coordinate with the state Emergency Management Division (EMD) to ensure that the response plans developed by the locals are consistent with the state Comprehensive Emergency Management Plan (CEMP). They are also allowed to, in the interest of time, disregard time-consuming requirements of law including budget law limitations, requirements of competitive bidding and publication of notices, entering into contracts, employment of temporary workers, rental of equipment, purchase of supplies and materials, levying of taxes, and appropriation and expenditures of public funds in the event of a public health emergency.

3. Local Public Safety Authority

   Local health officers are required to institute disease prevention and infection control measures, including quarantine when necessary, to prevent the spread of communicable diseases. Local law enforcement can be directed by the political subdivision executive head to cooperate in providing services in response to an emergency.

**State Agencies**

1. Department of Health

   The Department of Health is required to provide leadership and coordination in identifying and resolving threats to the public health by, among other things:

   - Providing expert advice to the executive and legislative branches of state government
   - Working with other federal, state, and local agencies and facilitating their involvement in planning and implementing health preservation measures
   - Providing information to the public

   The Secretary of Health is directed to:

   - Investigate outbreaks and epidemics of disease that may occur
   - Advise local health officers of the best steps to take to control and prevent outbreaks
   - Investigate any article or condition constituting a threat to the public health, including outbreaks of communicable diseases, food poisoning and contaminated water supplies

   The secretary and his or her representatives are allowed free and unimpeded access to all buildings, yards, warehouses, storage and transportation facilities or any other place as needed to carry on an investigation of a potential public health threat.

2. State Board of Health

   The board adopts rules for the use of isolation and quarantine and for the prevention and control of infectious and noninfectious diseases. Local boards of health, health authorities and officials, officers of state institutions, police officers, sheriffs, constables, and all other officers and employees of the state, or any county, city or township are required by law to enforce all rules adopted by the state Board of Health. Members of the general public are legally required to cooperate with public health authorities in the investigation of cases and suspected cases of notifiable conditions or other communicable diseases and to cooperate with the implementation of infection control measures, including isolation and quarantine.

**Governor**

The Emergency Management Act authorizes the governor to assume direct operational control over all or any part of the emergency management functions within this state if there is a disaster beyond local control.

In the event of an emergency proclamation, the governor is authorized to command the service of as many citizens as considered necessary in the light of the disaster proclaimed. The governor has legal authority to proclaim an emergency after finding that a public disorder, disaster, energy emergency, or riot exists within this state or any part thereof which affects life, health, property, or the public peace. The public use of certain streets and even the right to assemble can be disallowed by the governor to protect the safety and health of Washington citizens during a public health emergency.

* *A more detailed description of the authority for state public health partners to respond to a public health emergency, including statutory references, can be found in the appendix, as can a detailed list of local health contacts across Washington State.*

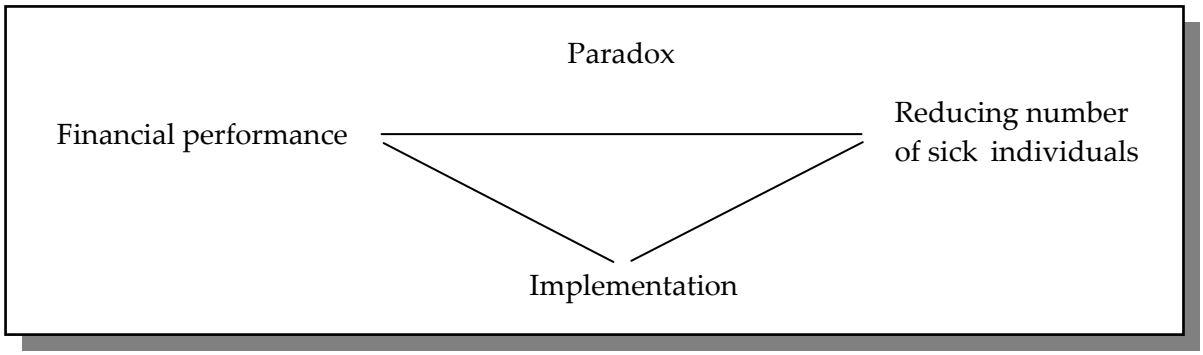
## Public Health Issue Context

The public health environment is a dizzying array of issues ranging from safe drinking water to licensing of facilities where life and death decisions are made daily. Every day in Washington State:

- The state Department of Health, the state Board of Health, 35 local health jurisdictions, 95 licensed hospitals and many other partners work together to ensure our communities are prepared for public health emergencies.
- About 210 babies are born, and newborn screening helps them get a healthy start through early detection and prompt care of treatable diseases.
- More than 5 million people have safe, reliable drinking water.
- More than 160,000 women and young children receive healthy food from the WIC program in local communities.
- 35 people call the Tobacco Quit Line and take the first step toward kicking the habit.
- Department of Health and boards and commissions license and regulate thousands of doctors, nurses and other health care professionals.
- 1,500 people receive emergency medical services in their homes, businesses and public places.
- More than 2.5 million people eat in restaurants with confidence thanks to food safety programs.
- About 95 percent of kids entering school are protected against preventable diseases because of public health immunization efforts
- More than 400 samples are tested by the state Public Health Laboratories for diseases like West Nile virus and the flu.

** Data from December 2004 Source: the department website, Public Health System Overview*

Part of the difficulty facing staff is found in the inherent dilemmas and paradoxes of the work. Public policy development is always a mix of priorities and solutions, none of which is perfect. Science might suggest one policy approach, while state finances might suggest another. Science might suggest a population wide solution to a public health issue, while politics among public stakeholders require implementation limits. A dilemma is a situation in which we are forced to choose between two legitimate alternatives. Paradox is found when neither of the extremes of two or more approaches is adequate alone. For example, in hospital based health care, monthly financial reports look better in the months when the most people are sick, while the mission of the institution is healing.




Given the health care system we have, all sides of this paradox must be considered at the same time, where as a dilemma requires an uncomfortable choice between alternatives. As hundreds of hospitals have learned, both financial considerations and dedicated efforts to improve health, must be included in daily activities, even with the risk that there will be fewer future patients. Policy makers don't get to chose between the two.

Policy makers must also consider implementation. A policy must not only be effective from health and financial perspectives. All the partners of the public health system must be able to implement the new requirements. Consequently, the public health ideal is not always the policy finally adopted.

The board and the department must work through similar paradoxes. One example arose when the board was considering whether to require immunity against varicella (chickenpox) for children entering school or child care. Varicella causes significant illness and sometimes leads to hospitalization and even death. Washington purchases vaccines for all children in the state – a policy called "universal purchase". It makes these purchases using a combination of state and federal dollars. The board wanted to add varicella to the list of diseases school children must be immunized against as a way of increasing the use of varicella vaccine in the state. But by increasing vaccine utilization, the board would also be driving up the cost to the state of purchasing the necessary doses of vaccine. Schools had serious concerns about whether they had the resources to implement this new requirement.

The chart above also illustrates the paradox that the board, the department, schools and the Office of the Superintendent of Public Instruction (OSPI), and the Office of Financial Management (OFM) faced. The public health goal was to reduce the number of people that became sick from varicella. But policy making had to consider the financial performance of the state budget as well as the implementation issues raised by both the schools, OSPI and the department (which could not adequately implement both the new requirement and the vaccine purchasing program without additional funding). The board adopted the proposed requirement and the legislature provided additional funds.

This situation could be considered simply a dilemma: selecting between spending additional funds or exposing children to a predictable risk. It only becomes a paradox when it is not possible to make such a choice, for example, if there were no additional funds. Paradox management can produce new ways of thinking within constraints if neither extreme can be selected. What could be done if there was a set amount of money and a vital need to increase vaccination rates? Changing relationships with or the thinking of vaccine suppliers or finding new ways to prevent varicella are only two possibilities. Thinking outside the "b ox" is required.

**Facilitator Tip:**
What dilemmas are you aware of?

Example: Scientific evidence suggests one rate of immunization while state and private funding require a less frequent approach.

What paradoxical issues exist in public health administration, just because it is public health administration?

Example: Public input to the Board is important to policy making. Often however, the more public input there is, the more complex the issue becomes.

**Facilitator Tip for Board Orientation:**
What public pressures or considerations are you currently facing?

What paradoxes have you faced in your public service?

## The Meeting of Science, Technology and Public Policy

One of the most important factors to explore as a new participant in policy development is the meeting of science and public interests. For a person devoted to good science, it can be very frustrating to see an approach carefully crafted from scientific data change when politics, funding and implementation issues are added. Participants must continually combine perspectives to optimize the entire system of policy making and know when to take a firm stand and when to adjust expectations.

As an illustration of the complexity involved in the work of the department and the board, consider the following table. This matrix provides a framework for developing policy from scientific, technical and public policy perspectives. A scientist unaccustomed to policy development might know, for example, that something would be considered valid within accepted scientific tolerances, but overlook the adjustments in policy necessary after public input is included. Likewise, a policy maker who is not familiar with the precise language and standards in scientific research might over emphasize public opinion and make decisions that are not scientifically sound.

The framework offered here is a tool for the department program staff, state board staff and board members to explore the differing perspectives of their partners. In the left hand column, there is a list of issues that must be addressed in establishing a policy. Across the top are potential perspectives of research scientist, technical experts drafting policy, policy makers who may or may not have a science background and general public stakeholders. Not all of the questions apply to every situation. The intention here is not to provide a decision making process, but a vehicle for exploration and understanding.

**Facilitator Tip:**
In a facilitated discussion, ask the participants for policy examples they know of, and be sure to provide your own examples to help generate understanding. This discussion should last 10 to 15 minutes.

In 2003, following discussions like those in the matrix, the Newborn Screening Advisory Committee of the State Board of Health made a number of recommendations to the board. As a result, the board adopted five criteria for evaluating any additional mandated newborn screenings and accepted a recommendation to begin screening for five new disorders. The five criteria include: (1) prevention potential and medical rationale, (2) treatment available, (3) public health rationale, (4) available technology, and (5) cost-benefit/cost-effectiveness. Any disorder that met the first four criteria, the committee recommended, should then be evaluated using the fifth criterion. Further

discussions resulted in the policy letter shown in Appendix A. The letter illustrates the many considerations to establish or adjust policies so that they are valid scientifically, useable in policy frameworks, acceptable to board members and acceptable to stakeholders.

## An Illustration of How Science and Stakeholder Involvement Inform Policy

| Issue Category | Questions For Scientist Doing Research | Questions for Technical Expert Using Data | Questions from Public Stakeholders | Questions for Policy Maker |
|---|---|---|---|---|
| **Validity - Reliability** | Will the results be "true" and will repeated measurements bear the same answer? | Have they done this enough to avoid chance?<br>Is this "truth" recognizable? | Are you sure you are not moving to fast?<br>Have you considered all the options? | Can I trust this information to make my decision? |
| **Precision and Trust** | Is my measurement detailed enough?<br>Is it precise enough to answer the question? | Will the scientific community trust this evaluation? | Can I really trust government or researchers to find the right answer? | Is this information helpful? (e.g., just because we can measure minute quantities or gather detailed information, does it matter? Do we know what it means?) |
| **Durability** | Is the instrument used current and best available at time of evaluation? | Will the information hold up over time? | I've seen government pronouncements before and then change a few years later. How do I know this is really the answer this time? | Can I use this for public policy that lasts years? |
| **Currency** | Is this a current method of testing? | How current is this answer? | I don't understand all these new-fangled methods. Why not just do it like my grand folks did… | Is this information timely for my policy decision? |
| **Corroboration** | Has my question has been asked by others in the scientific community? | Are there other results that support the same conclusion? | I have seen websites that dispute this finding. Why are you ignoring their work? | Have other policymakers (communities, states, countries) used this same information when they make their decision? |

## An Illustration of How Science and Stakeholder Involvement Inform Policy *(continued)*

| Issue Category | Questions For Scientist Doing Research | Questions for Technical Expert Using Data | Questions from Public Stakeholders | Questions for Policy Maker |
|---|---|---|---|---|
| **Applicability** | Can this evaluation completed with just a small number of subjects be extrapolated to a larger whole? | Does this answer change when applied to a larger group of people? | It may work for rats or small groups, will it work for me? | Will this answer be useful in policy formulation for a population? |
| **Relevance in Washington** | Who is the population most at risk and is the population I am evaluating representative of the whole? | Is this answer relevant to populations at risk in Washington? | I'd like to see things work for Washington, but how do I know this will be good for my particular community? | Should I use this information in policy formulation for WA population? |
| **World Context** | What are the external variables that can't be controlled? | What else is going on in the world that might impact this information? | Why should we care what goes on in other parts of the world unless we can control it? | Is this information the true answer for my population's need? |
| **Implications, Beneficiaries and Cost Bearers** | | Is there enough of the right data to respond to analysis requirements? | Who's going to pay for all this? What's it going to cost me and my children? | What is the impact /what are the consequences of this information and this decision?<br>Is this "fix" permanent or short term?<br>Does short term gain out-weigh long term repercussion?<br>Will the political environment tolerate this decision?<br>What are the potential risks? |

# Section 3: Partnership for Policy Development

Policy development uses data, other information, and community values to address community health problems or to build community capacity. At the same time, it weighs the costs and benefits of policy options, choosing a desired option, and recommending programs and services to carry out that policy. (*From The Power of Policy and Partnership, by Patty Hayes. A PowerPoint presentation.*)

To a newcomer, the range of authorities for policy and rule development can be very confusing. In some areas, rule and policy making is assigned to the board, in others to the department, in others to specialty boards operating under the department and in still others the board delegates authority to the department (See Appendix C). In addition, the Legislature and governor can initiate changes in public health policy. Sometimes changes are initiated in federal agencies and the department simply applies the changes to the state requirements.

For anyone new to the various parties' responsibilities for policy, it is helpful to review Title 246 WAC, Rules Statutory Authority, as an initial reference. It is located in Appendix F. If someone is initiating work on a particular policy or rule, it is particularly important to consult the footnote for each item to learn specific authorities for individual rules. The footnotes frequently refer to RCW 43.20.050, the board's authorizing statute.

The department and board are fortunate to have offices and individuals who work regularly with public health policy development, which involves a huge amount of information. For the department, there is an agency wide liaison, a rules liaison and liaisons for various divisions. At a minimum, these individuals should be consulted at the earliest possible date to learn the background and authority on any specific topic.

**Facilitator Tip**:
Be sure to provide an up to date list of liaisons and mentors.

## Beginning a new partnership or improving an existing one

Even with a basic understanding of the complex and fast-paced environment of public health, it is easy to overlook the work required to maintain good relationships. In fact, the expectations of the Chair of the Board of Health and the Secretary of Health are higher than simply good relationships. They have asked for well tuned partnerships in which all the players coordinate activity to effectively use time, talent and commitment to public health and to do so over and over again. How will people do that?

In a case in mid-2005, individuals from various offices in the department and the Executive Director of the board met to resolve issues in a then current rule making process. They developed the following set of principles to guide on-going partnership. By keeping these principles in mind, they will be able to anticipate difficulties and quickly recover if problems occur.

- The work gets done.
- Policy issues enter through designated liaisons.
- The right people are at meetings.
- There is follow-up.
- A game plan is set for current situation.
- Time is structured for reflection (Notice, thoughts, adjustments).
- Team members survive and finish with a willingness to do the next project.
- Team members watch for warning signals that relationships and processes are strained, such as people leaving meetings or other interactions with different understandings / interpretations / commitments / actions.
- Team members clarify what hat, role or authority they are operating from in a given moment.
- Team members distinguish working on specific issues from building a long-term strategic plan.
- Team members know who the decision authority is in each situation.
- Team members develop a combined list of stakeholders.

**Facilitator Tip:**
Ask the group to select the top 10 principles they believe will help fulfill a project's objectives for all parties.

The group also realized that typical group membership roles come into play that cannot be assigned to any single individual. Any member of the partnership can take on these functions and all need to be filled at some point in the life of a project.

- Taking clear positions.
- Prioritizing issues.
- Examining implications.
- Leveraging / linking issues or activities.
- Building long term strategy.
- Maintaining boundaries of roles / authority.
- Filtering / interpreting / focusing to make working context clear at each level.
- Informing – sharing information.
- Assigning – saying who does what in the current situation.
- Agitating – asking provocative questions, challenging thinking.
- Making connections – the function of liaisons.

- Requesting information.
- Taking action.
- Acknowledging contributions.
- Interpreting history.
- Explaining context.
- Testing for understanding, acceptance and support.
- Blocking action to prevent precipitous decision making.
- Referring to higher authority.

Learning how to facilitate group dynamics requires more time than this orientation allows. The point here is to be aware that normal group issues are present every time a collection of people meet. If the people working on a policy are having difficulty, chances are one or more of these functions are missing. Seek advice from someone more experienced than you are in managing board-department partnership.

**Facilitator Tip:**
Again, be sure to provide an up-to-date list of mentors and liaisons.

## Staff Development to Support Partnership: Freedom Scale

Collaboration within and across agencies requires a new understanding of relationships and of their evolution. Trust is a key component of partnership, but how can it be developed over time? While it would be nice to assume that trust is instantaneous, it is more realistic to say that through experience people develop confidence and trust.

One way to explore that evolution is illustrated in the following five levels of trusting relationships in a work setting. As staff members are assigned new responsibilities or are hired for new positions, they must learn both the skills of the new work and the amount of freedom appropriate to do the job. Freedom, in this context, means the degree to which the individual freely carries out responsibilities in ways that enhance the partnership and deepen trust.

Examples of these partnerships in department-board work are the relationships between:

a new office director and the department's board liaison
a program team member and the assistant secretary for his or her area
an executive director for the board and a new board chair
a department's program staff and the staff of the board.

The following levels are intended to assist the parties to any partnership in understanding how much checking or coordination is needed to optimize their combined work.

**Level 1**: A new staff member. The person might be new to the role, the environment, the procedures, the relationships or the context, even if technically experienced. It is common for the person, especially those inexperienced in the specific working environment, to wait until being told what to do. People can seem to be passive or reluctant while in their minds they are being respectful. This level is less common for higher leadership levels, although it might be dangerous to assume a higher level if one is new to his or her role. Some managers or partners become annoyed if a new person acts at a higher level. Likewise, the new person can become frustrated if not allowed to move up the scale.

**Level 2**: Staff member asks what to do. The person has begun to take responsibility for work assignments, but is not yet sure what to do. By asking what to do, the person helps define his or her own freedom. This level can become frustrating for the other partner who automatically assumes the person should know without asking.

**Level 3**: Staff member acts and reports immediately on what she or he has done. This can be effective for an experienced person in a new position as a way of calibrating the freedom she or he will be granted in the partnership. It helps assure their partner that

the person is aware of boundaries and limits. Experienced partners can help the new person by expressing appreciation for the check-in and by explaining what needs checking and what doesn't.

**Level 4**: Staff member acts and reports on a regular, established basis. Work gets done without immediate coordination and reports are made on an established schedule. The higher trust experienced in this level is appropriate for capable staff members who have demonstrated they understand context, methods, boundaries and sensitivities associated with their work and the partnership. If an experienced person (who had similar responsibilities elsewhere) is not allowed to get to this point quickly, frustrations and feeling of being 'micromanaged" begin to creep in.

**Level 5**: Staff member acts and reporting is assumed. Level 5 only works when the partners are well aligned in responsibilities, style and long term direction. There needs to be a common understanding of when to check in and when to ask for help. At this level, it is helpful to have a "weather gauge" known to all that indicates when something is developing that requires new coordination, such as the Mid-Point Huddles described in Section 6. Level 5 is often incorrectly assumed among experienced, mature workers who over-extend their assumptions about independence. It is suppressed by partners who are not comfortable unless they know everything that is going on.

**Special situations**: The level appropriate to any partnership can shift when circumstances change as in the case of an issue that has suddenly become politically sensitive. Each member of a partnership should stay alert for changes and let the others know when a new understanding is needed. In fact, the awareness of shifting circumstances and willingness to engage partners to renegotiate agreements is a hallmark of strong partnership.

**Movement among levels**: All of the levels apply at least to some extent to everyone in an organization like a state agency, even at the very top. Everyone makes assumptions about the level of their interaction. Being clear and intentionally progressing up the scale helps use people's capabilities and capacity to learn. On the other hand, when surprises occur, and a partner is caught off guard on something for which they feel responsible, the scale can easily reverse and an increased desire for control can occur. Rapid recovery from mistakes can be made by using honest mid-point huddles as described elsewhere in this guide, but in the hectic / stressful environments of most work places, these conversations are often ignored. When that happens, conflict tends to increase.

(Adapted from: Freedom Scale – unknown origin, given to Sam Magill by Richard Olefs in 1984.)

**Facilitator Tip:** Ask participants to reflect on their partnership experience. In your interactions with board or department staff members, where on the scale do you most frequently find yourself? If you are new to board-department interactions, what other work partnerships have you experienced and where have you found yourself on the scale? In either case, what could you do or request from others to move up the scale?

# Section 4: Detailed Roles of Department and Board Leaders and Staff

Many individuals and offices play roles in managing the development and change of policies. The following lists describe the positions or roles most commonly involved in policy development in the department and the board. Please remember that these are general representation of work related to board-department partnerships and are not complete or formal job descriptions.

## State Board of Health

### Board Member Roles

Board members bring their own expertise to their work, but they also represent constituencies. The secretary represents the Department of Health and the governor. One member represents local health officers and is often a conduit for checking with other health officers on policy issues. One member represents elected city officials and another represents elected county officials. Two members represent the public and four must "be experienced in matters of health and sanitation." At least one of those four typically has ties to local environmental health leadership and one must be affiliated with a federally recognized tribe.

The board has policy committees that provide direction on strategic initiatives. Committees develop work plans, author the board's reports, and can bring proposals directly to the board without a second on a motion being required. They often review and make recommendations on requests to the board before they go to the full board.

Rule making always has a board sponsor. The sponsor is kept abreast of developments throughout the process. The executive director always consults with the sponsor before signing a CR-101 or CR-102 (a CR-103 requires full board action). The sponsor may work closely with one of the policy committees, and the board chair is also consulted on controversial rules. Department staff sometimes request direct consultation with the sponsor at key junctures. A policy committee or individual board member will also sponsor policy development activities. Sponsors introduce most agenda items at board meetings and review materials and the list of invited speakers in advance.

### Board Chair Roles

The board chair fills four main functions:

- Has the lead role in identifying policy work, especially the work that falls outside of rules.
- Makes sure the voice of all stakeholders is heard in policy work.
- Works closely with staff to build agenda and book of business for the board.

- Lead spokesperson for the board except where another board member is the topic lead.

The chair also supervises the executive director providing direction on administrative matters, directing legislative activities during session, and signing all correspondence that represents a position of the entire board.

## Executive Director Roles

The executive director develops budgets (spending plans and allotments) in consultation with the executive assistant, approves expenses and signs contracts, and reviews expenditures against the budget monthly with the executive assistant and the budget analyst assigned by department. He or she informs the chair and the deputy secretary of any significant deviations. He or she also develops the staffing plan in consultation with the chair, makes hiring decisions (for most staff members this requires concurrence of the department deputy secretary), and informs the chair of hiring decisions prior to formalizing or announcing. This is done in close coordination with the human resources consultant assigned by the department. The board executive director also supervises most staff, approves job descriptions, develops evaluations, training plans and performance measures, and disciplines if necessary (in consultation with human resources consultant).

The executive director is involved at an executive, supervisory level with all policy activities and rule making and is lead staff for helping the board develop its strategic plans and work plans. She or he works with the staff to develop agendas for the board meetings. Those agendas go to the chair for review and approval before publication.

She or he is legislative liaison for the agency, and in that role coordinates internal bill review, attends department bill reviews, works with legislative staff to improve bills, testifies before legislative committees if a board member is not available, and meets with legislators as necessary. This person also compares bills against the board's statutory authority, policy activities, strategic plan, and "statement of the board on legislative issues" and recommends positions (support, support concept, oppose, recommend amendment, remain neutral) and actions (testify, contact staff, request meeting, send letter, do nothing) to the chair.

As interagency liaison, the executive director handles negotiations with department and other agencies and the Governor's Office about initiating collaborative efforts and establishing or clarifying the board's role in policy issues. He or she maintains regular contacts with senior management at agencies with overlapping responsibilities, and if there is conflict between agencies, becomes involved in seeking resolution. This liaison role also extends to local health, citizen groups and professional associations.

The executive director is policy lead on a limited number of the board's policy initiatives development (e.g. mental health), serves on some policy development bodies where executive-level participation is requested (e.g., Agency Medical Directors Group), staffs the Access Committee, and oversees development of the State Health Report. She or he is also the primary media contact for the board, overseeing the work of the communications consultant, initiating media contacts on timely issues, responding to requests for information, and speaking for the board when a board member is not available. A significant part of this job involves monitoring scientific, legal, policy, fiscal and political developments and advising the board on its authorizing environment.

## Board Staff Roles (Rule Making)

The board and department employ many different strategies for rule making, ranging from the board delegating authority to the department to the board developing the rule in house with the department acting as a stakeholder. Typically, the board asks the department program with the technical expertise and implementation responsibilities to develop the rule and bring a draft to the board for consideration. At key points in the process, the program will collaborate with the board policy analyst assigned to the rule and perhaps with the board sponsor. The following explains the roles of board policy staff during typical rule making, but there will be exceptions. Roles for board and department staff should be clearly defined in the pre-huddle, and if roles shift during the process, that shift should be clearly articulated and agreed to in a subsequent huddle.

**Initiating rule making:** Consult with department staff on need for rule making and timing. Identify related policy issues board members may wish to address. Identify board sponsor. If the department requests delegation, advise on whether request would be consistent with board policy. Help determine whether full board review of the proposal and formal action are needed. Serve as intermediary to board members in establishing whether and how to proceed. Review timeline to ensure board members expectations are met.

**Stakeholder work:** Consult on which stakeholders should be involved. Review interested parties list and list of meeting invitees. Review interested parties' letters before they go out. Interested parties letters should go jointly from department and the board (program manager/executive director or assistant secretary/board sponsor). Responses should be directed to the program. Attend stakeholder meetings to understand rule implications. Provide leadership and help identify solutions when problems arise. Board staff members' may maintain and develop their own relationships with stakeholders during the rule development process, but board staff should let the department program know about stakeholder contacts outside the process established by the department.

**Rule writing:** Review rule changes to be sure they are in synch with board's expectations. Edit if necessary to assure clarity and quality of writing. Specifically address issues related to scope of board authority. Identify problems and propose solutions. Facilitate communication between program and board members. Make sure there are no surprises for board sponsors. Board executive director signs CR-102.

**Board presentations:** Review presentations and packets to make sure they are clear and accurate and anticipate board questions and concerns. Inform program about likely questions and concerns from board members. Ghostwrite cover memos from board sponsors. Answer questions the program is not able to address.

**Implementation:** Review implementation plan, making sure it is consistent with the intent of the rule.

## Department of Health Staff

### Secretary of Health

The Secretary's of Health's responsibilities include:

- Secretary of the department
- Active board Member
- Representative of governor and her health agenda
- Providing oversight of the department presentations to the board

### State Health Officer

The state health officer serves as the chief medical officer for the state of Washington and is chief medical/ public health advisor to the governor, secretary, State Board of Health, local boards of health and local health agencies. The state health officer represents the agency on the board in the secretary's or deputy secretary's absence; may serve as a member on advisory committees appointed by the board; and may advise the board on broad array of clinical, epidemiological, and other public health related issues.

### Deputy Secretary

The deputy secretary provides a conduit for the board staff to agency internal resources and support services, on issues such as rent, supply needs, budget coordination, and human resource issues. The deputy may help with problem solving on litigious issues and may assist through facilitation and interventions.

The deputy represents the agency on the board in the secretary's absence and is charged with representing the interest of the agency and the governor. That includes oversight of agency resources and alignment with governor's and agency priorities. The deputy also assures staff work is complete and focused.

## Director, Policy Legislative and Constituent Relations (PLCR)

The director of policy, legislative, and constituent relations directs policy, legislative, and constituent relations for the Department of Health with primary responsibility for the department's policy, legislative, regulatory, economic analysis, congressional, and constituent relations programs.

The director, as the interagency liaison, represents the secretary and the department to elected officials, federal, state, and local health agencies, health consumers and other constituent groups concerned about health. The director serves as spokesperson for the department in matters affecting legislation and health policy at the federal, state, and local levels.

The director also works with and provides support to assistant secretaries, division directors and programs in carrying out their policy, legislative, and rule responsibilities. This position assists with the coordination of policy development, rule development and legislative efforts across divisions and assures agency-wide analysis of issues. This position also reviews all rules for policy and political issues before they go to the secretary for approval.

## Assistant Director, Policy Legislative and Constituent Relations (PLCR)

The assistant director of policy, legislative, and constituent relations serves as one of the agency's legislative liaisons. This position assists with the coordination of policy development, rule development and legislative efforts across divisions and assures agency-wide analysis of issues. The assistant director helps manage the progress of Department of Health agency request legislation and budget proposals through the legislative process.

This position serves as the department's liaison to the board, and monitors all regular board meetings to identify and track major regulatory and policy issues potentially impacting other agency programs, politically sensitive issues, or potentially litigious issues. This position maintains regular contact with department management and the executive director, and if problems are identified helps assure the appropriate individuals are engaged.

## Regulatory Affairs Manager

The regulatory affairs manager serves as a consultant to the board and staff regarding regulatory issues such as: the rules process, statutory requirements, and working with department staff. The regulatory affairs manager helps facilitate communication between program staff and board staff; and coordinates preparation of staff and materials for presentations-- reviewing and editing department-produced materials for content, clarity, and tone.

The regulatory affairs manager plans, directs, and assures the implementation of executive orders on regulatory reform and new legislative requirements pertaining to regulatory reform and rule development. This position assures the timely and consistent application of these requirements across the agency, and reports agency results to senior management, the Office of Financial Management, and/or the legislature. This position also determines sufficiency of rule proposals at all stages prior to secretary's approval and publication outside of the agency, and requires additional information or work from program or division staff on those proposals that are inadequate or incomplete.

### Assistant Secretaries

The assistant secretary presents materials as requested to the board on issues that reside at least partially within his or her respective division or that division staff have provided information. The assistant secretary provides technical recommendations from staff on a board issue - where technical consultation is requested. This position provides support to the secretary in preparing materials for her or his use for board work in arenas which the division is support or technical advisor. Assistant secretaries may present high visibility issues to the board.

On an informal level, the assistant secretary answers questions from board members regarding the current routine practice or service provided by his or her division for public health efforts. The assistant secretary provides contact information for other technical advisors or specialists or stakeholders who may need to be consulted or included in a board hearing or presentation. This individual may help staff problem solve issues; and may meet with the board's executive director to resolve communication and other issues.

### Division Policy Director / Legislative Liaison

The division policy director/ legislative liaison works with the board on rule development issues, overseeing division rulemaking activities, and guiding staff through policy development. This person also works with board staff if there are communication issues. Additional activities may include:

- Assisting staff in developing rule or briefing documents;
- Participating in stakeholder relations with program staff;
- Participating in a team effort to resolve issues and reach compromise. This individual is always alerted when there is an issue of concern between the board and a division staff, such as differences in interests, goals, and policy stance;
- Keeping the agency rules manager and policy director apprised of any conflicts related to rule making or overlapping activities where the board and the division have an interest.

### Division Rules Staff

Division rules staff help coordinate and develop rules at the division level. This position's responsibilities as they relate to the board center on ensuring necessary information are available to board members to make policy decisions on rules. Depending on the rule, this individual may prepare materials or review and comment on materials prepared by others. This position is responsible for assuring rules follow the agency's procedural requirements and meet legal requirements, as well as assuring that appropriate staff is involved in the drafting and development of rules.

### Office Director

The office director is responsible for several programs that implement board rules. The office director and his or her staff assist the board and stakeholders in reviewing and revising these rules when needed. Specifically, this position:

- Reviews recommendations for changes in state rules in his or her program area (These recommendations may be made by federal partners (CDC), national organizations (Council of State and Territorial Epidemiologists), local groups or advocacy organizations (HIV Policy Summit), local health officials, or by department staff)
- Discuss and make recommendations regarding rule changes with department management and the need for rule change with executive director (and board staff);
- Work with board sponsor and lead board staff in developing the rule;
- Arrange and hold and sometimes facilitate stakeholder meetings, in coordination with board staff;
- Serve as point of contact for comments on draft proposals; and
- Provide briefings or testimony before the board

### Program Manager / Staff

The program manager and program staff provide the office director with information relating to program operation for board briefings or presentations. Their roles in rule development vary depending on the staffing levels. If a program is well-staffed, these individuals can more easily take the lead on most activities (e.g., revision drafts, public meetings, stakeholder work, etc.). In other situations, the board staff is more involved. Overall, much of the communication with the board is done through the Assistant Secretary's Office and PLCR. With regard to rule revisions, these staff:

- Assist the board with the public process involved in exploring the issues,
- Generate options for resolution,
- Create draft rule documents for public review, and finalize rule proposals for the board's consideration

# Board and Department Statement of Needs and Expectations to Create a Positive and Functional Working Relationship

## Mutual Needs and Expectations

- Communication during rule development should be candid, timely, focus on achieving overall goals (don't get stuck on tactics), and treated with the proper level of confidentiality. (See section on rapid huddles)
- Communication during legislative session should be timely, may be informal, need not await formal bill review opportunities, and should be sensitive to potential impacts on each agency. Changes in policy position should be communicated as quickly and directly as possible.
- Communication on policy issues should be clear, should explain rationale but not expect others have to agree with your position, should attempt to identify agency and board position and goals, with attention to common desires and gaps.
- Interactions between the department and the board should be carried out with the same degree of professionalism and respect as dealings with any other agency, association, or client group.
- The need for confidentiality and candor as policy issues are developed should be clearly articulated and respected. Robust and rigorous policy discussions should not be discouraged but rather viewed as a value-added step in the creative process.
- Each agency should expect its staff and personnel to adequately inform their respective management structure of progress and status.

## State Board of Health Needs and Expectations of the Department

The board needs:

- A designated liaison in the department to serve as point of contact on policy and rule development issues.
- Clarity from the department on who has policy approval authority on specific items or projects.
- A designated liaison in the department to serve as point of contact on business issues and needs (space, rent, internal support systems, budget development, etc).
- Timely notification of pending changes in business practices, OFM directives, or other actions that may impact day-to-day operations.
- Timely notification of legislative or other inquires directed to the department about the board, and maximum inclusion in discussions as feasible.

## Department of Health Needs and Expectations of the Board

- The department needs board requests for information and staffing assistance to go through division appointing authorities or their designees, so that workload impacts and properly authorized staff are fully known.
- As "landlord" for the board's office, the department needs to know of space and/or business needs as soon as possible, especially if there are issues that are creating barriers to board performance.
- The department needs to have as much pre-alert as possible when the board is launching an initiative or policy effort that will require department participation, staffing assistance or impact workload.

**Facilitator Tip:**
Check to see if each participant knows who the appointing authority or designee is. If someone does not know, assist them in finding out.

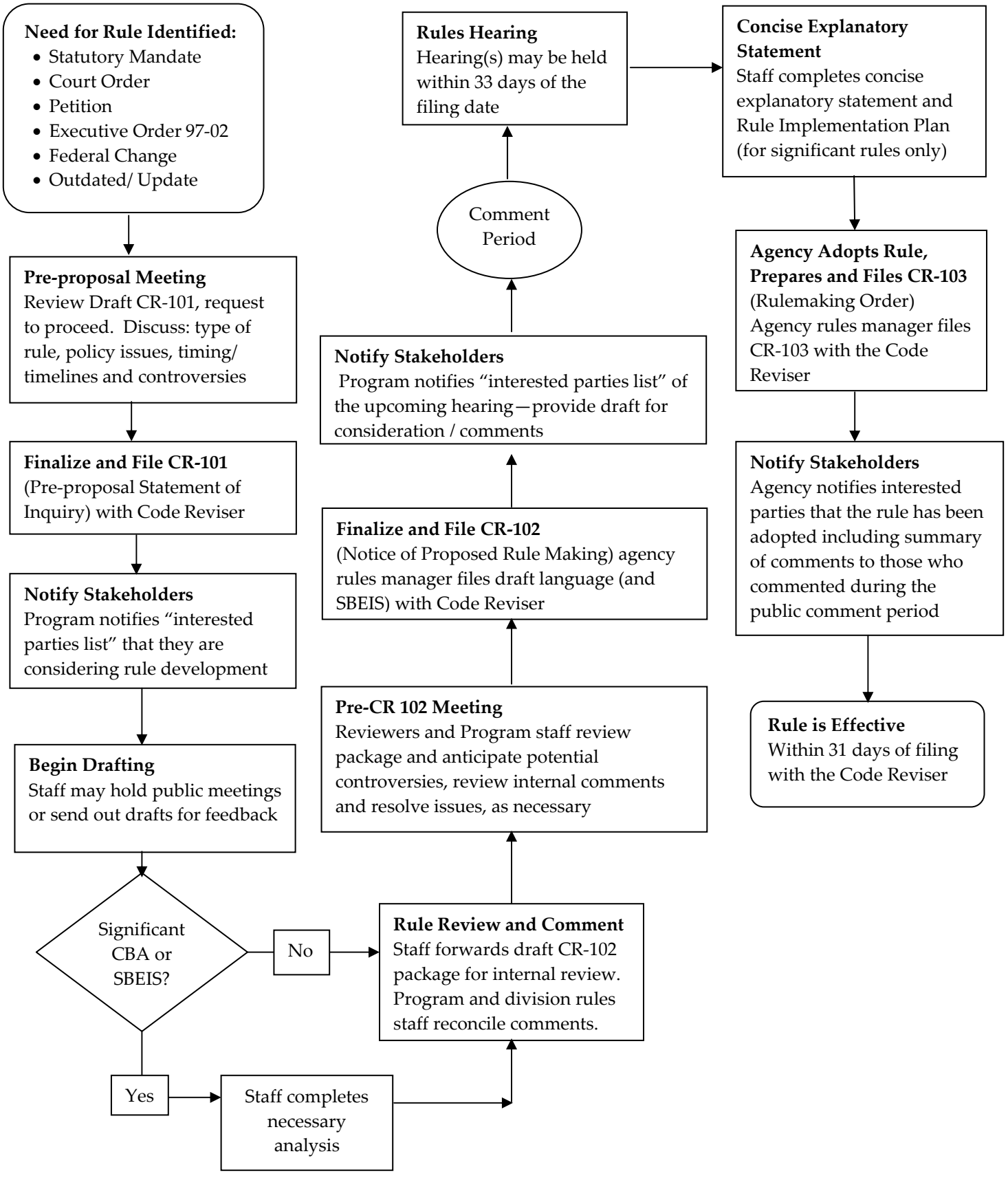
# Section 5: Policy and Rule Development Processes

Policies, as we have seen earlier, are documents that provide guidelines, regulations, position statements and other frameworks deemed necessary to fairly and effectively administer public health standards in our state. For this project between the State Board of Health and the State Department of Health, formally adopted rules are one of the primary, but not exclusive, means for establishing policy. Because there are certain rules for which the board has authority and certain others for which the department has authority, two processes are being followed. Both of the processes require the use of the state's rule making steps and notifications called CR101, CR102 and CR 103. Each step requires certain information and decisions, and each one requires a signature to indicate completion.

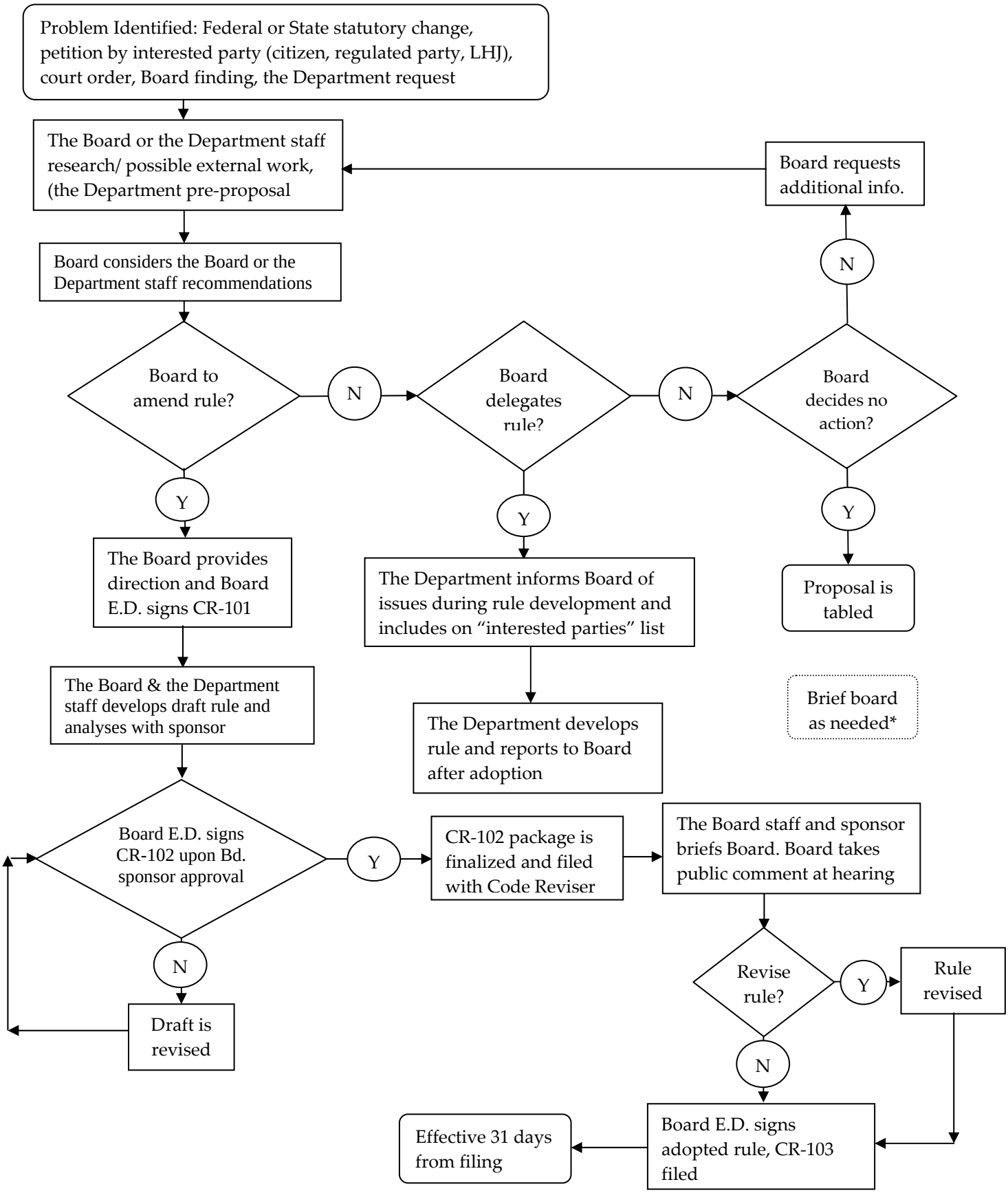
The principle difference between the two is that rules for which the department has authority do not have to go before the board. Various reviews occur within the department and with stakeholders, but the steps necessary for presenting the rule at a board meeting are not necessary.

**Facilitator Tip:**
Spend a few minutes letting people review the processes. If there is no one in the room who has experience using them, record questions and send to the rules liaison as soon as possible after the meeting.

# Department of Health Basic Rule Process



## State Board of Health Rules Process




*The board should be briefed on emerging issues or as requested by the board staff or sponsor assigned to the rule.

# Section 6: Maintaining Collaboration Through Rapid Huddles

Complex work environments require communication systems that are more robust than traditional static, silo or top down interactions. Because responsibilities are dispersed among many organizations, levels and functions, a method is needed to keep the "whole system" informed and coordinated.

The idea of "rapid huddles" was initiated by John Schuster and Patricia Kane in a book titled *Open System Management.* While their context was for-profit corporations, the core concepts fit the board – department partnership as well.

Schuster and Kane created the practice of bringing people together regularly and rapidly to look at performance indicators that had both direct relevance to the individual (what they could control by their actions) and to the corporation. The primary indicators in their approach are financial at the collective and unit levels and the book's premise is that open financial books increase the ability of employees to be accountable. The key application of open systems management for this orientation guide is open books of information, which may include financial considerations, but will generally include policy related information.

While the board and the department are interdependent and aligned in a mission to increase and protect the health of citizens, there are times when the two organization's methods and emphases diverge. That challenge, the rapid pace of work and the reactive-political environment in which they work all contribute to occasional breakdowns of relationships. Furthermore, it is difficult for individuals to gauge success in their own accountability when there are so many players and agendas. Even so, the board chair and secretary of the department have set the high goal of being proactive to avoid relational or process breakdowns.

How can "rapid huddles" help? The short, quickly planned meetings suggested here have six major goals:

1. Understand the context of what is happening and why.
2. Provide full disclosure of objectives for any given project (from each party's perspective).
3. Know who the players are at all organization levels.
4. Learn from experiences to continually improve processes.
5. Join in the huddles to rapidly recover from mistakes, miscommunication or other breakdowns.
6. Generate broad understanding of why and how proposed changes will help meet board and department objectives.

**Facilitator Tip:**
Ask participants to write down and discuss a case of any interoffice or interagency work they have seen in which there were challenges related to one of the five issues listed above. What clarification might have helped them?

The following three templates provide guidelines for huddles at the earliest possible stage, midpoint corrections and review at the end of a project. Agreement on issues is valuable, but clarity and awareness of the various activities and perspectives is even more important. With regard to rule development, huddles are intended to supplement the regularly scheduled rule meetings.

*Pre Huddle: Meet for no more than one hour*

**Who calls it**: Typically board or department liaisons, but also anyone who initiates policy or rule development.
**Who attends**: All the principle participants in a given board - department project.
**What sort of meeting**: A conversation to establish:

Roles
Authorities
Understanding
Importance
Audience / stakeholders
Existing positions / sentiments
History of the topic including past rule making, if applicable

**When is it held**: At the moment someone decides to initiate a project or when theCR101 has been signed.

*Pre Huddle Worksheet:*

As you anticipate calling and conducting a pre-huddle, fill in as many of the following items as possible. Provide copies to everyone in attendance. At the meeting fill in and adjust all the remaining items until there is clarity. If there is substantive disagreement, attempt to resolve it. ( If that is not possible, note the perspectives and who holds them. This keeps all the information on the table and allows the group to realign later. )

Issue/ Topic / Policy / Rule:

Authorities and scope of authority:

Department or team initiating this meeting:

Purpose / Context of the project:

Audience / Stakeholders:

Current situation: e.g., known positions

Brief History: e.g., previous projects, process difficulties and lessons

Players / participants: **Please note this is an example**. Participants and roles will shift depending on the situation. A blank table is included in the appendix.

| Participant (not a group) | Contribution to this project | Initial Tasks |
|---|---|---|
| Office Director | Expert knowledge of varicella, national connections and<br>• Resource awareness<br>• | Identify changes in science since last update. Establish list of stakeholders. Identify stakeholder issues, concerns, or positions. Authorizing environment. |
| Program Staff Member | Technical expertise<br>•<br>• | Provide preliminary stakeholder list for consideration in huddle. |
| Department Regulatory Affairs Manager | Clarify schedule and rule requirements<br>•<br>• | Review stakeholder lists, identify areas requiring analysis. |
| Board Executive Director | Approve Office of Code Reviser filings<br>•<br>• | Approve CR-101. |
| Board Policy Staff Member | Serve as liaison to Board sponsor<br>• | Help identify initial goals that reflect Board's interests. |
| Division Policy Director/ Leg. Liaison | Assessment of Political Environment | |

**How do you know you are done with this huddle?**

There is common understanding of the above AND

You know when you will meet again (situation or time and date)

For complex, many party projects, plan regular (e.g. monthly or quarterly) meetings to touch base in person – could be half an hour.

**Who calls the Pre-huddle?**

The department-board liaison, board executive director, program manager, office director, assistant secretary, division policy director/ legislative liaison, other.

*Mid Point Check in:*

**When is it held**: As agreed or when any member of the "team" believes there are emerging misunderstandings or conflicts, or when the project has gotten "tangled."

**Who calls it**: Any member of the project staff – the department or the board.

**Who attends**: As many of the pre-huddle participants as possible, plus others as needed.

**How is it conducted**:

1. **Notice**: Look for when the conversation becomes crucial, when it has become unsafe to speak or when someone is under increasing stress. E.g., do you find yourself staying silent when inside you are fuming? Are others trying to talk and not being heard?
2. **Make a request for a huddle**. Assume good intention when asked to attend.
3. **State the reason the meeting was called.** Identify what was happening that lead to the call before saying the result sought.
4. **Ask what others are observing**. Agreement is not required so much as listening.
5. **State what you really want**, such as getting information sooner or not being surprised by a shift in position at the last minute. Listen to what others want.
6. **Make it safe**. Get clear on your own contribution – e.g., not speaking up about your own discomfort two months before. Reconnect with the intention of the project. Listen to others' perspectives.
7. As a group, **identify adjustments** needed to the "pre-huddle worksheet"

*Post Huddle*

**When is it held:** As soon as possible after the project is complete.
**Who calls it**: The person who called the pre-huddle.
**Who attends**: The original group plus others who have become involved.
**What is discussed:**

1. What did you notice?
2. What do you think and feel about that?

3. What did you learn?
4. What could be done better on a future project?
5. What do you need to say in order to feel complete with this project?
6. Acknowledge the contribution of participants?

In concluding this discussion of *rapid huddles*, it is useful to remember that the investment of time to adjust working agreements, role and emerging issues is like preventative maintenance on a car. Sometimes getting the oil changed and tires rotated is inconvenient, yet the consequences are cumulative. It is important to remember that both the department and the board are strongly committed to improving and maintaining the health of people in Washington State. Finally, the public expects cooperation among state agencies and is quick to point out when there is confusion, conflict or duplication of effort. The work is hard enough without miscommunication and mixed agendas. Perhaps the most important potential outcome of this project is a common framework to be able to address differences effectively. Ultimately, however, it is up to each individual on the board, its staff or the department to maintain the partnership in the midst of slightly different and important roles.

# Section 7: Appendices

# Appendix A

## Policy Development Example

The following memorandum from Board Chair, Kim Marie Thorburn, represents a fully developed policy, including background and board action.

**Facilitator Tip:**
As you look through this example, talk about what program units and offices would have been involved from the Department of Health. What science and policy issues might have emerged?

October 12, 2005

**TO:** Washington State Board of Health Members

**FROM:** Dr. Kim Marie Thorburn, Board Chair

**SUBJECT: NEWBORN CYSTIC FIBROSIS SCREENING AND THE ACMG REPORT**

**Background and Summary**

In 2002 Dr. Thomas Locke and Dr. Maxine Hayes concluded their work with a Newborn Screening Advisory Committee, which had been asked to: (1) develop criteria to use when considering new disorders for the mandatory screening panel and (2) consider whether any additional disorders should be added to the panel.

In 2003 the board adopted five criteria to consider when evaluating new disorders, and it added to the screening panel five new disorders that had been evaluated using the new criteria. The Advisory Committee did not recommend adding cystic fibrosis at that time but asked that the Board re-evaluate this decision in two years as more science became available.

At its December 2004 meeting, the board asked the Department of Health (the department) to begin the re-evaluation process. In April 2005 a panel of technical experts reviewed the new science that was available and recommended that a larger advisory panel proceed with a full evaluation of cystic fibrosis using the five criteria adopted by the board in 2003. The larger advisory committee met in July 2005 to further review cystic fibrosis against the five criteria and make recommendations to the board. These

recommendations are included in your packet (under Tab 6 in the *Review of Criteria for Adding Cystic Fibrosis to NBS Program*).

Medical and technological advances in recent years have made it feasible to screen newborns for a larger number of disorders. Many disorders can be detected using the same dried blood specimen that is routinely collected to test infants in Washington State. In 2004, the United States Department of Health and Human Services' Secretary's Advisory Committee on Heritable Disorders and Genetic Diseases in Newborns and Children accepted a report commissioned from the American College of Medical Genetics (ACMG). This report recommends 29 disorders for newborn screening. Eighteen of these twenty-nine disorders (including hearing loss and cystic fibrosis) are currently not screened for in Washington State.

Today, I have invited Dr. Thomas Locke, former Board Chair; Dr. Maxine Hayes, State Health Officer; and Mike Glass, Director of the Washington State Newborn Screening Program, to talk about the recommendations from the cystic fibrosis advisory committee. I have also asked the department staff to update the board on the Newborn Screening Annual Report findings and Specialty Clinic fees. According to WAC 246-650-040, the department is required to provide annual reports to the board on the following information concerning tests: (1) the costs of tests as charged by the department; (2) the results of each category of tests, by county of birth and ethnic group, as reported on the newborn screening form and, if available, birth certificates; and (3) follow-up procedures and the results of such follow-up procedures.

Finally, I have invited the department to present its review of the ACMG report. In December 2005, the board asked the department to determine if there are effective interventions for the 16 conditions that have not yet been evaluated for inclusion in Washington's screening battery, and also to provide some sense of the associated costs; Washington's capacity to detect and treat the disorders; and the number of newborns in Washington who could potentially be identified with the conditions. the department has reviewed the report as requested and will present its findings today (see Tab 6 *Synopsis: National Recommendations*).

**Recommended Board Action**

**Motion 1:**

***The board requests that the department continue the rule making process that would add cystic fibrosis to the list of preventable heritable disorders leading to developmental disabilities or physical defects in Chapter 246-650 WAC.***

**Motion 2:**

***The board will work with the Department of Health to begin a process to review the conditions set forth in the American College of Medical Genetics' report that are currently not under consideration by the Board or included in Chapter 246-650 WAC. The conditions will be reviewed against the five Board-approved criteria for adding disorders to the newborn screening program and recommendations will be made regarding which, if any, the Board should consider adopting in rule.***

**Discussion**

*Cystic Fibrosis*

The rule: Washington's newborn screening law (Chapter 70.83 RCW—Phenylketonuria and Other Preventable Heritable Disorders) states that "the policy of the state of Washington to make every effort to detect as early as feasible and to prevent where possible phenylketonuria and other preventable heritable disorders leading to developmental disabilities or physical defects." The statute authorizes the board to determine which disorders in addition to phenylketonuria (PKU) are to be included in newborn screening required by the state. The statute also delegates authority to the department to require that all newborns receive screenings for the detection of the disorders that are defined by the board before they are discharged from the hospital.

In Chapter 246-650 WAC, the board has identified eight "preventable heritable disorders leading to developmental disabilities or physical defects" in addition to PKU. Currently, Washington State requires screening for PKU, congenital hypothyroidism, congenital adrenal hyperplasia, hemoglobinopathies such as sickle cell disease (which includes sickle cell anemia, Hb S/Beta-thalassemia, and Hb S/C disease), biotinidase deficiency, galactosemia, homocystinuria, medium chain acyl Co-A dehydrogenase deficiency (MCADD), and Maple Syrup Urine Disease (MSUD). The department tests for these disorders at the State Public Health Laboratory, an activity supported by a charge collected through the hospital or other birth facility.

The Process: Dr. Hayes and Dr. Locke co-chaired the Newborn Screening Advisory Committee, which concluded its work in 2002. In 2003 the Newborn Screening Advisory Committee made a number of recommendations to the board. As a result, the board adopted five criteria for evaluating any additional mandated newborn screenings and accepted a recommendation to begin screening for five new disorders. The five criteria include: (1) prevention potential and medical rationale, (2) treatment available, (3) public health rationale, (4) available technology, and (5) cost-benefit/cost-effectiveness. Any disorder that met the first four criteria, the committee recommended, should then be evaluated using the fifth criteria. Although the committee did not recommend adding cystic fibrosis to the list at that time, it strongly encouraged the board to re-evaluate this decision in two years when the results of several additional studies on early cystic

fibrosis treatment would be available. Since 2002, several studies have shed new light on therapeutic interventions and cost benefit/cost effectiveness of cystic fibrosis treatment.

At its meeting in December 2004, the board approved a motion to work with the department to convene a panel of technical experts to review new information available on the benefits of newborn screening for cystic fibrosis and make a preliminary determination whether this condition meets criteria established for newborn screening tests in Washington. A technical review committee of seven experts in public health and cystic fibrosis met on April 9, 2005. The committee's charge was to review current scientific and medical evidence regarding newborn screening for cystic fibrosis against the Board's five criteria for adding disorders to the state's mandatory screening program. The committee was asked if the evidence was sufficiently compelling to justify convening a broadly representative advisory committee to review all of the issues and make a formal recommendation to the Board as to whether cystic fibrosis should be added to the state's mandatory requirements. The technical review committee unanimously concluded that the research evidence is consistent with the criteria and that a larger advisory committee should be convened.

The larger advisory committee met in July 2005 to further review cystic fibrosis against the five criteria and make recommendations to the Board. The broader advisory committees' votes were unanimous on the first four criteria. While the majority (or nine of the fourteen committee members) felt the fifth criterion (cost-benefit/cost-effectiveness) was met, three of the committee members did not agree and there were also two abstentions. Several methodological issues arose that were subsequently addressed in consultation with a national expert. The revised analysis concludes that an estimated $5.40 in benefit will be realized for each dollar spent on screening-related costs.

The advisory committee also felt that careful implementation would be necessary to achieve the desired benefits, and made four implementation recommendations. These accompany the committee's scoring on the five criteria.

# Appendix B

## Department of Health Responsibilities

***The Department of Health works with federal, state and local partners to help people in Washington state stay healthy and safe. The department's programs and services help prevent illness and injury, promote healthy places to live and work, provide information and education to help people make good health decisions, and ensure our state is prepared for emergencies.***

Washington's 35 county-based local public health departments/districts are vital components of the state/local health system. The relationship between the department and local health departments/districts is an essential and statutory partnership, in addition to a stakeholder and contractual relationship. Much of the day-to-day work of public health is carried out in Washington communities by these local health departments, with support and coordination from the Department of Health.

- **Safe, high-quality health care services:** The department works with oversight groups to regulate health care providers and ensure they comply with health, safety and professional standards. **To ensure people receive professional, safe and reliable health care from qualified providers and facilities, the department:**
  - licenses health care providers and facilities
  - investigates complaints
  - disciplines health care providers who violate established standards
  - notifies the public of these violations
  - maintains a history of disciplinary actions on the Internet

- **Healthy, well-informed parents and healthy children: To make sure communities are safe and supportive of children, youth and families, and to ensure Washington families have well-informed parents and healthy infants, children and youth, the department provides:**
  - pre-natal care education for parents
  - nutrition and health education for pregnant women
  - vaccine for immunizations
  - food for those qualifying for the Women, Infants and Children (WIC) program, which provides food for those in need
  - health monitoring and testing for children
  - oral health assistance for children

- **Protect the public from and prevent the spread of communicable diseases:** The department, along with local health and other agencies, works to protect the public

from communicable diseases, such as tuberculosis, HIV/AIDS, and sexually-transmitted diseases. **To create an environment where the public is protected from communicable and infectious diseases, the department:**

- educates the public on how to avoid contracting and spreading the disease
- monitors the rate and frequency of infectious diseases and assists in the investigation of disease outbreaks
- pays for drugs and limited medical care for eligible HIV clients
- works with local health to provide confidential HIV testing
- works with public health partners to prevent and reduce the effects of communicable diseases

❖ **<u>Make sure shellfish and the food sold and served in Washington are safe to eat</u>: The department helps make sure that food from restaurants and other food service businesses is safe to eat, and shellfish from Washington waters are safe to eat, by:**

- monitoring local waters and beaches to make sure shellfish are safe to eat
- developing safe food handling and sanitation rules and guidelines for restaurants and other food service establishments, which are implemented by local health jurisdictions
- educating food service workers and the public on safe food handling

❖ **<u>Safe places to work and live</u>:** The department works with local public health jurisdictions and other agencies to promote healthy, safe communities. **To assure that the places people live, work and play are healthy and safe from hazards in the environment, the department:**

- educates the public on how to make and keep their environment safe and healthy
- develops environmental public health standards for small- and medium-sized septic systems
- monitors and helps prevent diseases spread by animals and humans
- monitors sources of radiation, radioactive materials and radioactive waste
- develops sanitation guidelines and rules for public facilities such as schools and swimming pools
- provides health information to communities to minimize or eliminate exposure to contaminants in the environment
- monitors and prevents pesticide-related illnesses

❖ **<u>Emergency preparedness and response</u>:** The department develops and coordinates efforts to prepare for and respond to public health emergencies such as natural disasters and terrorism threats. **To make sure public agencies are better equipped to help people through a public health emergency, the department:**

- develops and maintains state, regional and local emergency response plans
- provides training and exercises to emergency responders, from risk communication to mass vaccinations

- coordinates local, regional, state agency and tribal partnership development and assistance
- develops public education activities
- is continually increasing electronic communications between the department, local health agencies, hospitals and emergency response

❖ **<u>Safe, reliable drinking water</u>: The department works with local water systems and communities to make sure drinking water is safe and reliable by:**
- requiring on-going water quality monitoring and evaluating those results
- enforcing regulations for drinking water quality standards and for water system construction and operation
- conducting inspections of water systems assisting water systems and local communities when water is found to be unsafe
- providing training for water system operators to assure proper operation of the water system

❖ **<u>Chronic disease prevention and health promotion</u>:** The department works with local health departments, community groups and the media to provide resources, materials and tools to help educate the public how to be healthy and how to prevent disease and injury. **To make sure people have the information they need to prevent disease and injury, manage chronic conditions and make healthy decisions, the department's activities include:**
- tobacco prevention and control efforts for communities and schools
- injury prevention strategies for children and seniors
- stressing the importance of physical activity and proper nutrition
- diabetes prevention and control
- breast and cervical cancer screenings
- cancer and cardiovascular disease education
- posting safety and health information on the department's Web site

❖ **<u>Public Health Laboratories</u>:** Provides accurate and timely laboratory results. Only the U.S. Centers for Disease Control and Prevention provides more advanced testing. **To make sure public health departments and health care providers receive accurate and timely science-based information to use when making decisions about public health, the laboratories test a wide range of specimens for:**
- communicable disease
- shellfish toxins
- foodborne illnesses
- genetic diseases in newborns
- contamination of air, water and food

❖

**Strengthening the public health network:** The department works to strengthen its partnerships with public health, particularly those agencies at a community level. **To make sure the public health network is resilient, effective and is coordinated and responsive to the public's needs, the Department:**

- provides resources for emergency medical and trauma services
- promotes access to health care in rural communities
- increases electronic communications between the department, local health agencies, hospitals and emergency response
- institutes electronic reporting of disease
- convenes the Public Health Improvement Partnership and uses their advice to make the best use of public health resources
- provides resources for public health workforce development
- coordinates response to emerging health issues with federal, state and local partners
- offers certified copies of birth, death, divorce and marriage records to the public
- builds and supports information networks to provide data that promotes good decision-making about public health

# Appendix C

Washington State Board of Health

## Policy for Considering Delegation of Rules to the Department of Health

In some instances, the Washington State Board of Health (SBOH) may determine it is appropriate to delegate its authority for rulemaking to the Department of Health (DOH).[1] The SBOH and DOH recognize the need to balance both broad constituent participation and administrative efficiency when making decisions about any rule delegation.

For this reason, SBOH and DOH have agreed upon a set of criteria to assist Board members in their decisions related to rule delegation.

The decision to delegate a specific rule will always be made on a case-by-case basis. The parameters of that decision will be determined at the time of delegation and may range from specific aspects of a rule to a broader body of regulatory authority (i.e., all drinking water or farm worker housing regulations). Once a rule has been delegated, the Board expects to be kept informed about the rule making process in the form of progress reports. The Board also maintains the authority to rescind delegation if necessary.[2]

When considering delegation of authority to modify or adopt a rule, the SBOH may consider the following.

- The extent to which the proposed rule revision is expected to include editorial and/or grammatical changes that do not change the substance of the rule;
- The extent to which the proposed rule seeks to adopt federal requirements in which the state has little or no discretion;
- The extent to which the substance and direction of the proposed rule is expected to have broad public and professional consensus;
- The extent to which the proposed rule may make significant changes to a policy or regulatory program; and
- The extent to which the rule revision process would benefit from the Board's role as a convener of interested parties.

[1] RCW 43.20.050 "The state board may delegate any of its rule-adopting authority to the secretary and rescind such delegated authority."

[2] ibid.



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Approved by the Board: 11/08/00 S:\Rules\delegate.doc

# Appendix D

## Huddle Worksheets
## Copy As Needed

**Pre Huddle: Meet for no more than one hour**

Pre Huddle Worksheet:
As you anticipate calling and conducting a Pre-huddle, fill in as many of the following items as possible. Provide copies to everyone in attendance. At the meeting fill in and adjust all the items until there is clarity. If there is substantive disagreement, attempt to resolve it, and if that is not possible, note the perspectives and who holds them. This keeps all the information on the table and allows the group to realign down the road.

Issue/ Topic / Policy / Rule:

Authorities / Scope of Authorities

Individual initiating this meeting:

Purpose / Context of the project:

Players / participants: Please note this is an example. A blank table is included in the appendix.

| Participant (not a group) | Contribution to This Project | Initial Tasks |
|---|---|---|
| | | |
| | | |
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| | | |

Audience / stakeholders for the project:

Current situation: (e.g., known positions, views, climate)

Brief History: (e.g., previous related projects, process difficulties and lessons)

**How do you know you are done with this huddle?**

There is common understanding of the above AND

You know when you will meet again (situation as much as time and date)

For a complex, many party projects, plan regular (e.g. monthly or quarterly) meetings to touch base in person – could be half an hour.

**Mid Point Check in:**

**When is it held**: As agreed or when any member of the "team" believes there are emerging misunderstandings or conflicts or the project has gotten "tangled".

**Who calls it**: Any member of the project staff – the department or the board.

**Who attends**: The "pre-meeting" participants as possible, plus others as needed.

**How is it conducted:**

1. **Notice**: Look for when the conversation becomes crucial, when it has become unsafe to speak or when someone is under increasing stress. For example, do you find yourself staying silent when inside you are fuming? Are others trying to talk and not being heard?
2. **Make a request for a huddle**. Assume good intention when asked to attend.
3. **State the reason the meeting was called.** Identify what was happening that lead to the call before saying the result sought.
4. **Ask for what others are observing**. Agreement is not required so much as listening.
5. **State what you really want**, such as getting information sooner or not being surprised by a shift in position at the last minute. Listen to what others want
6. **Make it safe**. Get clear on your own contribution – e.g. not speaking up about your own discomfort two months ago either. Reconnect with the intention of the project. Listen to others' perspectives.
7. As a group, **identify adjustments** needed to the "Pre-Huddle Worksheet"

**Post Huddle**

**When is it held**: As soon as possible after the project is complete.
**Who calls it**: The person who called the Pre-huddle.
**Who attends**: The original group plus others who have become involved.
**What is discussed**: To answer debriefing questions.

1. What did you notice?
2. What do you think and feel about that?
3. What did you learn?
4. What could be done better on a future project?
5. What do you need to say in order to feel complete with this project?
6. Acknowledge the contribution of participants?

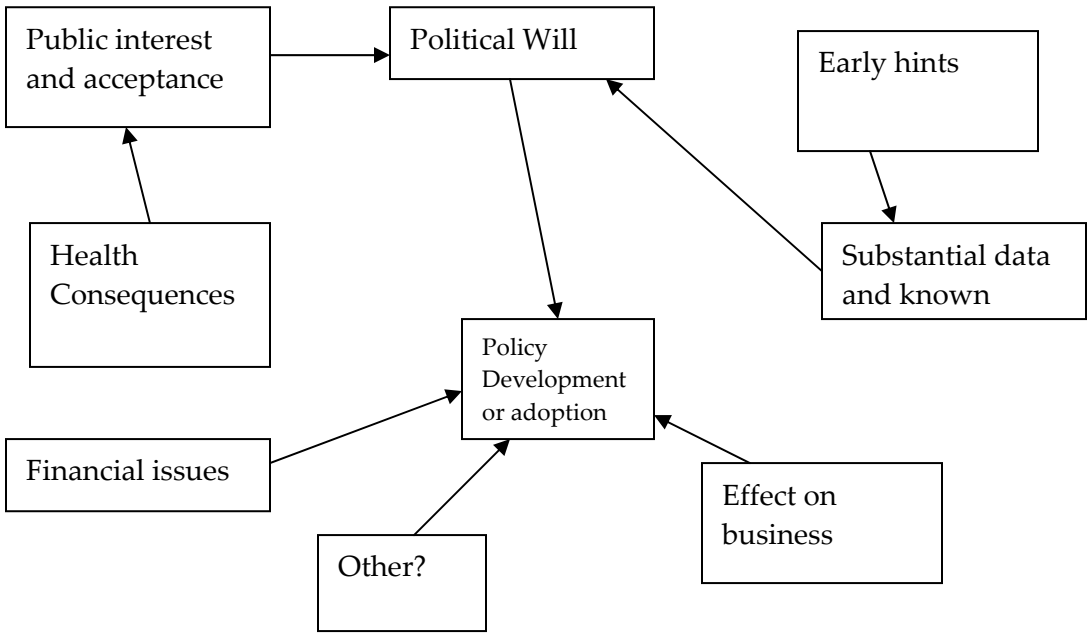
# Appendix E

## Emergence of Policy

The following diagram might be useful for facilitators to help generate understanding of how policy emerges. As an example, smoking cessation laws began with physical evidence being noticed. Medical scientists started discussing the blacked lungs they were seeing. At the time, social norms suggested that smoking was utterly acceptable, even expected. Hollywood consistently presented stars as smokers. Consequently, any cautions about the effect of smoking were ignored or even mocked.

As more evidence was gathered, the conversation began to shift and laws, especially in Washington State, eventually became stringent.

What other cases are familiar to participants? What is the route from initial thinking to formal policies, rules and laws?



# Appendix F

## Title 246 WAC
## Rules Statutory Authority

**LEGEND**
Chapter: WAC listing by chapter number
WAC Section: Identifies whether the entity adopting the rule has authority for the entire chapter, or discreet sections*.
RCW: Statutory authority to adopt rules currently identified
Adopting Authority: Entity with statutory authority to adopt the rule
DIV: Department of Health Division that most recently amended the rule
FED: Identifies rules that are affected by federal law or regulation
LHJ: Identifies rules that Local Health Jurisdictions are responsible for implementing.
*Excluding Health Professions chapters.

| Chapter | WAC Section(s) | Title | RCW | Adopting Authority | DIV | FED | LHJ |
|---|---|---|---|---|---|---|---|
| 246-01 | Entire chapter | Description and organization | 43.70.040 | Secretary | OS | | |
| 246-03 | Entire chapter | SEPA guidelines | 43.21C.120; 43.70.040 | Secretary | EH | | |
| 246-08 | Entire chapter | Practice and procedure | 43.70.040, 43.70.050, 70.02.050 & 70.02.010 | Secretary | OS | | |
| 246-10 | Entire chapter | Adjudicative proceedings | 43.70.040 | Secretary | HSQA | | |
| 246-11 | Entire chapter | Model procedural rules for boards | 18.130, 34.05 | Secretary | HSQA | | |
| 246-12 | Entire chapter | Administrative procedures & requirements for credentialed health care providers | 43.70.280 | Secretary | HSQA | | |
| 246-14 | Entire chapter | Uniform procedures for complaint resolution | 18.130.095 | Secretary | HSQA | | |
| 246-15 | Entire chapter | Whistleblower rules | 43.70.075 | Secretary | HSQA | | |
| 246-16 | Entire chapter | Standards of Professional Conduct | 18.130.050, 18.130.180 | Secretary | HSQA | | |
| 246-25 | Entire chapter | Anti-trust Immunity and Competitive Oversight | 43.72.310 | Secretary | HSQA | | |
| 246-50 | Entire chapter | Coordinated quality improvement program | 43.70.510 | Secretary | OS | | |
| 246-100 | Entire chapter | Communicable and other certain diseases-- definitions | 43.20.050, 70.05.050, 70.05.060, 70.24.125, 28a.210.140, 70.24.130, 70.24.380 | State Board Of Health | CFH, EHSPHL, EH | | ✓ |

| Chapter | WAC Section(s) | Title | RCW | Adopting Authority | DIV | FED | LHJ |
|---|---|---|---|---|---|---|---|
| 246-101 | Entire chapter | Notifiable conditions | 43.20.050, 70.24.125, 70.28.010, 43.70.545, 70.104.030 | State Board Of Health/Secretary | CFH; EHSPHL; EH | | ✓ |
| 246-102 | Entire chapter | Cancer registry | 70.54.270 | Secretary | CFH | | |
| 246-110 | Entire chapter | Contagious disease—school districts and day care centers | 43.20.050 | State Board Of Health | EHSPHL | | ✓ |
| 246-130 | Entire chapter | HIV infection interventions | 43.70.120 | Secretary | CFH | | |
| 246-136 | Entire chapter | Human immunodeficiency virus (HIV) infection -- occupational exposure notification | 70.24.107 | Secretary | CFH | | ✓ |
| 246-138 | Entire chapter | Testing of good Samaritans for certain infectious diseases | 70.05.180 | Secretary | CFH | | ✓ |
| 246-140 | Entire chapter | Bloodborne pathogens in children placed in out-of-home care. | 74.13.289 | Secretary | CFH | | |
| 246-145 | Entire chapter | Electrology and tattooing standards for sterilization procedures and infection | 70.54.340 | Secretary | OS | | |
| 246-170 | Entire chapter | Tuberculosis--prevention, treatment & control | 70.28.032, 70.33.020 | Secretary/State Board of Health | CFH | | ✓ |
| 246-203 | Entire chapter | General sanitation | 43.20.050 | State Board Of Health | EH | | ✓ |
| 246-205 | Entire chapter | Decontamination of illegal drug sites | 64.40.060, 64.40.070 & 64.44 | Secretary/ State Board Of Health | EH | | ✓ |
| 246-215 | Entire chapter | Food service | 43.20.050, 43.20.145 & 69.80.060 | State Board Of Health | EH | | ✓ |
| 246-217 | Entire chapter | Food worker cards | 43.20.050, 69.06 | State Board Of Health | EH | | ✓ |
| 246-220 | Entire chapter | Radiation protection--general provisions | 43.70.040, 70.98.050 70.98.080 | Secretary | EH | ✓ | |
| 246-221 | Entire chapter | Radiation protection standards | 43.70.040, 70.98.050 70.98.080 | Secretary | EH | ✓ | |
| 246-222 | Entire chapter | Radiation protection--worker rights | 43.70.040, 70.98.050 70.98.080 | Secretary | EH | | |
| 246-224 | Entire chapter | Radiation protection--machine assembly and registration | 43.70.040, 70.98.050 70.98.080 | Secretary | EH | ✓ | |
| 246-225 | Entire chapter | Radiation protection--x-rays in the healing arts | 43.70.040, 70.98.050 70.98.080 | Secretary | EH | ✓ | |
| 246-227 | Entire chapter | Radiation protection--industrial x-rays | 43.70.040, 70.98.050 70.98.080 | Secretary | EH | ✓ | |
| 246-228 | Entire chapter | Radiation protection--general provisions | 43.70.040, 70.98.050 70.98.080 | Secretary | EH | ✓ | |
| 246-229 | Entire chapter | Radiation protection--particle accelerators | 43.70.040, 70.98.050 70.98.080 | Secretary | EH | ✓ | |

| Chapter | WAC Section(s) | Title | RCW | Adopting Authority | DIV | FED | LHJ |
|---|---|---|---|---|---|---|---|
| 246-231 | Entire chapter | Packaging and transportation of radioactive material | 70.98.050 | Secretary | EH | ✓ | |
| 246-232 | Entire chapter | Radioactive material--licensing applicability | 43.70.040, 70.98.050 70.98.080 | Secretary | EH | ✓ | |
| 246-233 | Entire chapter | Radioactive materials--general licenses | 43.70.040, 70.98.050 70.98.080 | Secretary | EH | ✓ | |
| 246-235 | Entire chapter | Radioactive materials--specific licenses | 43.70.040, 70.98.050 70.98.080 | Secretary | EH | ✓ | |
| 246-239 | Entire chapter | Radiation protection--nuclear medicine | 43.70.040, 70.98.050 70.98.080 | Secretary | EH | ✓ | |
| 246-240 | Entire chapter | Radiation protection--medical therapy | 43.70.040, 70.98.050 70.98.080 | Secretary | EH | ✓ | |
| 246-243 | Entire chapter | Radiation protection--industrial radiography | 43.70.040, 70.98.050 70.98.080 | Secretary | EH | ✓ | |
| 246-244 | Entire chapter | Radiation protection--wireline services | 43.70.040, 70.98.050 70.98.080 | Secretary | EH | ✓ | |
| 246-246 | Entire chapter | Radioactive criteria for license termination | 70.98.050 | Secretary | EH | | |
| 246-247 | Entire chapter | Radiation protection--air emissions | 43.70.040, 70.94.161 & .422, 70.98.050 & .080 | Secretary | EH | ✓ | |
| 246-249 | Entire chapter | Radioactive waste use of the commercial disposal site | 43.70.040, 70.98.060 & .080 | Secretary | EH | ✓ | |
| 246-250 | Entire chapter | Radioactive waste--licensing land disposal | 43.70.040, 70.98.050 & .080 | Secretary | EH | ✓ | |
| 246-252 | Entire chapter | Radiation protection--uranium and/or thorium milling | 43.70.040, 70.98.050 & .080 | Secretary | EH | ✓ | |
| 246-254 | Entire chapter | Radiation protection--fees | 43.70.040 & .110, 70.98.080 | Secretary | EH | | |
| 246-260 | Entire chapter | Water recreation facilities | 70.90.120, 43.20.050 | State Board Of Health | EH | | ✓ |
| 246-262 | Entire chapter | Recreational water contact facilities | 70.90.120, 43.20.050 | State Board Of Health | EH | | ✓ |
| 246-270 | Entire chapter | Sewer systems--certification for water district involvement | 43.20.050, 43.70.040, 57.08.065 | Secretary/ State Board Of Health | EH | | |
| 246-271 | Entire chapter | Public sewage | 43.20.050 | State Board Of Health | EH | | ✓ |
| 246-272 | Entire chapter | On-site sewage systems | 43.20.050 | State Board Of Health | EH | | ✓ |
| 246-272A | Entire chapter | On-site sewage systems | 43.20.050 | State Board Of Health | EH | | ✓ |
| 246-272B | Entire chapter | Large on-site sewage systems | 43.20.050 | State Board Of Health | EH | | ✓ |
| 246-273 | Entire chapter | On-site sewage system additives | 70.118 | Secretary | EH | | |
| 246-280 | Entire chapter | Recreational shellfish beaches | 43.20.050 | State Board Of Health | EH | | ✓ |

| Chapter | WAC Section(s) | Title | RCW | Adopting Authority | DIV | FED | LHJ |
|---|---|---|---|---|---|---|---|
| 246-282 | Entire chapter | Sanitary control of shellfish | 69.30.030, 43.20.050 | State Board Of Health | EH | ✓ | |
| 246-290 | Entire chapter | Group A public water supplies | 43.20.050, 70.119A.080, 43.20B.020, 43.70, 70.05, 70.116, 70.119, 70.142 | State Board Of Health | EH | ✓ | ✓ |
| 246-291 | Entire chapter | Group B public water systems | 43.20.050, 43.20B.020, 43.70, 70.05, 70.116, 70.119A | State Board Of Health | EH | | ✓ |
| 246-292 | Entire chapter | Water works operator certification | 70.119.050 | Secretary | EH | ✓ | |
| 246-293 | Entire chapter | Water system coordination act | 70.116.080 | Secretary | EH | | |
| 246-294 | Entire chapter | Drinking water operating permits | 70.119A | Secretary | EH | | |
| 246-295 | Entire chapter | Satellite system management agencies | 70.116.134, 43.20, 43.20B.020, 43.70, 70.116, 70.119, 70.119A | Secretary | EH | ✓ | |
| 246-296 | Entire chapter | Drinking water state revolving fund | 70.119A.170 | Secretary | EH | ✓ | |
| 246-305 | Entire chapter | Certification independent review organizations | 43.70.235, 48.43.535 | Secretary | HSQA | | |
| 246-310 | Entire chapter | Certificate of need | 70.38.135 | Secretary | HSQA | | |
| 246-312 | Entire chapter | Acquisition of non-profit hospitals | 70.45.140 | Secretary | HSQA | | |
| 246-314 | Entire chapter | Construction review fees | 43.70.110, 43.70.250 & 43.20B.020 | Secretary | HSQA | | |
| 246-320 | Entire chapter | Hospital licensing regulations | 70.41.030 | Secretary | HSQA | | |
| 246-322 | Entire chapter | Private psychiatric and alcoholism hospitals | 71.12 & 43.70.040 | Secretary | HSQA | | |
| 246-324 | Entire chapter | Private alcohol and chemical dependency hospitals | 71.12 & 43.70.040, 43.70.110 & 43.70.250 | Secretary | HSQA | | |
| 246-329 | Entire chapter | Childbirth centers | 18.46.060, 43.43.830-842 | Secretary | HSQA | | |
| 246-335 | Entire chapter | In-home services agencies | 70.127 | Secretary | HSQA | | |
| 246-337 | Entire chapter | Residential treatment facility | 71.12 | Secretary | HSQA | | |
| 246-338 | Entire chapter | Medical test site rules | 70.42 | Secretary | HSQA | | |
| 246-358 | Entire chapter | Temporary worker housing | 70.54.110, 43.70.040, 43.70.340 | Secretary | HSQA | | |
| 246-359 | Entire chapter | Temporary worker housing construction standard | 70.114A.041, 43.70.337 | Secretary | HSQA | | |
| 246-360 | Entire chapter | Transient accommodations | 70.62.240, 43.70.110 & 250 | State Board Of Health | HSQA | | ✓ |
| 246-361 | Entire chapter | Cherry harvest camps | 70.114A.065, 70.114A.110 | Secretary | HSQA | | |

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|---|---|---|---|---|---|---|---|
| 246-366 | Entire chapter | Primary and secondary schools | 43.20.050 | State Board Of Health | EH | | ✓ |
| 246-374 | Entire chapter | Outdoor music festivals | 43.20.050 | State Board Of Health | EH | | ✓ |
| 246-376 | Entire chapter | Camps | 43.20.050 | State Board Of Health | EH | | ✓ |
| 246-380 | Entire chapter | State institutions and DOC facilities | 43.20B.020 | Secretary | HSQA | | |
| 246-390 | Entire chapter | Drinking water laboratory certification rules | 43.20.050 | Secretary/ State Board Of Health | EHSPHL | ✓ | ✓ |
| 246-451 | Entire chapter | Hospitals--Assessments and related reports | 70.170.080 | Secretary | EHSPHL | | |
| 246-453 | Entire chapter | Hospital charity care | 70.170.010 & 70.170.060 | Secretary | EHSPHL | | |
| 246-454 | Entire chapter | Hospitals--Systems of accounting, financial reporting, budgeting, cost allocation | 43.70.052 | Secretary | EHSPHL | | |
| 246-455 | Entire chapter | Hospital patient discharge information reporting | 43.70.052 | Secretary | EHSPHL | | |
| 246-490 | Entire chapter | Vital statistics | 43.70.040, 43.70.050, 43.70.150; 43.20.050, 70.58.082, 70.58.104 | Secretary/ State Board Of Health | EHSPHL | | ✓ |
| 246-491 | Entire chapter | Vital statistics certificates | 70.58.055; 43.70.040 | State Board Of Health/ Secretary | EHSPHL | ✓ | |
| 246-500 | Entire chapter | Handling and Care of Human Remains | 43.20.050, 18.39.215 | State Board of Health | EHSPHL | | ✓ |
| 246-560 | Entire chapter | Rural health system project | 70.175.030(3) | Secretary | HSQA | | |
| 246-562 | Entire chapter | Physician visa waiver | 70.185 | Secretary | HSQA | ✓ | |
| 246-564 | Entire chapter | Volunteer retired provider malpractice insurance program | 43.70.470 | Secretary | HSQA | | |
| 246-650 | Entire chapter | Newborn screening | 70.83.050 | State Board Of Health | EHSPHL/ CFH | | |
| 246-680 | Entire chapter | Prenatal tests -- congenital and heritable disorders | 48.21.244, 48.44.344, 48.46.375. | State Board Of Health | CFH | | |
| 246-710 | Entire chapter | Coordinated children's services | 43.20.140, 43.20A.635 | State Board Of Health | CFH | | |
| 246-760 | Entire chapter | Auditory and visual standards -- school districts | 28A.210.200 | State Board Of Health | CFH | | |
| 246-762 | Entire chapter | Scoliosis screening -- school districts | 28A.210.200 | State Board Of Health | CFH | | |
| 246-780 | Entire chapter | Farmers market nutrition program | 43.70.120 | Secretary | CFH | | |
| 246-790 | Entire chapter | Women, infant, children (WIC) supplemental nutrition program | 43.70.120 | Secretary | CFH | ✓ | |
| 246-800 | Entire chapter | General provisions--professionals | 69.50.311, 43.70.070 | Secretary | HSQA | | |
| 246-802 | Entire chapter | Acupuncturists | 18.06.160, 43.70.040 | Secretary | HSQA | | |

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|---|---|---|---|---|---|---|---|
| 246-808 | Entire chapter | Chiropractors | 18.25.020—070, .180, .190 | Chiropractic Quality Assurance Commission | HSQA | | |
| 246-809 | Entire chapter | Licensure for mental health counselors, marriage and family therapists, and social workers | 43.70.250, 18.225.040 | Secretary | HSQA | | |
| 246-810 | Entire chapter | Counselors--definitions | 18.19.040 – 060, 18.19.120, 18.130.070, 70.24.270, 43.70.250 | Secretary | HSQA | | |
| 246-811 | Entire chapter | Chemical dependency professionals | 18.205.060 | Secretary | HSQA | | |
| 246-812 | Entire chapter | Denture technology | 18.30.065 | Board Of Denture Technology | HSQA | | |
| 246-814 | Entire chapter | Access to dental care for children | 43.70.650 | Secretary | HSQA | | |
| 246-815 | Entire chapter | Dental hygienists--applications | 18.29.021, .040, .045, .050, .071, .076, .130; 43.24.020, 024; 18.130.070, 43.70.250 | Secretary | HSQA | | |
| 246-817 | Entire chapter | Dental quality assurance commission | 18.32.035 | Dental Quality Assurance Commission | HSQA | | |
| 246-822 | Entire chapter | Dietitians or nutritionists--definitions and general provisions | 18.138.040, .070, 18.130.050, 18.130.070, 43.70.040 | Secretary | HSQA | | |
| 246-824 | Entire chapter | Dispensing opticians--definitions | 73.70.040, 18.04.040, 43.70.040, 43.70.060, 43.70.250, 73.17.060, 18.130.070, 18.130.080, 18.34.040, 18.34.080, 43.17.060, 70.24.270 | Secretary | HSQA | | |
| 246-826 | Entire chapter | Health care assistants--delegation health care assistants | 18.135.030, 43.70.040, 70.24.270 | Secretary | HSQA | | |
| 246-828 | Entire chapter | Hearing aid fitters and dispensers--activities requiring license | 18.35.161 | Board | HSQA | | |
| 246-830 | Entire chapter | Massage practitioners | 18.108.025, 18.108.085, 70.24.270 | Secretary | HSQA | | |
| 246-834 | Entire chapter | Midwives | 18.50 | Secretary | HSQA | | |
| 246-836 | Entire chapter | Naturopathic physicians | 18.36A.060, 18.130.050, 18.180.070, 43.70.040, 70.24.270, 43.70.240 | Secretary | HSQA | | |
| 246-840 | Entire chapter | Practical and registered nursing | 18.69, 70.24.270; 18.79, 18.88.080; 18.130.050; 18.130.070, 18.130.180 | Nursing Quality Assurance Commission | HSQA | | |

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|---|---|---|---|---|---|---|---|
| 246-841 | 400, 405, 410-520, 710, 730, 740 | Nursing assistants--ed & training | 18.88A.050, 18.130.17 | Nursing Quality Assurance Commission | HSQA | | |
| 246-841 | 610, 720, 990 | Nursing assistants—AIDS Education | 70.24.270, 43.70.040 | Secretary | HSQA | | |
| 246-842 | Entire chapter | Nursing assistants -- nursing homes -- nursing assistants training program | 18.52.061 | Nursing Quality Assurance Commission | HSQA | | |
| 246-843 | Entire chapter | Nursing home administrators | 18.52.061 | Board of Nursing Home Administrators | HSQA | | |
| 246-845 | Entire chapter | Nursing pools | 43.70.250 | Secretary | HSQA | | |
| 246-847 | Entire chapter | Occupational therapists--definitions | 18.59.130, 18.59.180, 18.130.075 | Board of Occupational Therapy | HSQA | | |
| 246-849 | Entire chapter | Ocularists--general provisions | 18.130.040, 050, 18.130.070, 70.24.270, 18.55.095, 43.70.250 | Secretary | HSQA | | |
| 246-850 | Entire chapter | Orthotics and prosthetics | 18.200.050 | Secretary | HSQA | | |
| 246-851 | Entire chapter | Optometrists--renewal of licenses | 18.54.070, 70.24.270, 18.130.050, 18.130.186 | Board of Optometry | HSQA | | |
| 246-852 | Entire chapter | Consumer access to vision care | 18.195.050 | Secretary | HSQA | | |
| 246-853 | Entire chapter | Osteopathic physicians and surgeons | 18.57.005, 18.130.040 18.130.050 | Osteopathic Physicians Board | HSQA | | |
| 246-854 | 020-060, 090, 110, 115 | Osteopathic physicians' assistants | 18.57.005 | Osteopathic Physicians Board | HSQA | | |
| 246-854 | 080 | Osteopathic physicians' assistants--licensure | 18.57.005; 18.130.040 | Osteopathic Physicians Board /Secretary | HSQA | | |
| 246-855 | 010-040, 060-110 | Osteopathic physicians' acupuncture assistants | 18.57.005 | Osteopathic Physicians Board | HSQA | | |
| 246-855 | 050 | Osteopathic physicians' acupuncture assistants--investigation | 18.57.005, 18.130.040 | Osteopathic Physicians Board /Secretary | HSQA | | |
| 246-856 | Entire chapter | Board of pharmacy--general--licenses, registrations & certifications | 18.64.005 | Board of Pharmacy | HSQA | | |
| 246-858 | Entire chapter | Pharmacists-internships, preceptors | 18.64.005 | Board of Pharmacy | HSQA | | |
| 246-861 | Entire chapter | Pharmacists--professional pharmaceutical ed | 18.65.005 | Board of Pharmacy | HSQA | | |
| 246-863 | Entire chapter | Pharmacists--licensing-- licensure of pharmacists | 18.64.005 | Board of Pharmacy | HSQA | | |
| 246-865 | Entire chapter | Pharmaceutical services--extended care facilities | 18.64.005, 18.64A | Board of Pharmacy | HSQA | | |
| 246-867 | Entire chapter | Impaired pharmacist rehab--purpose and scope | 18.64.005, 18.64A, 18.130.050 | Board of Pharmacy | HSQA | | |

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|---|---|---|---|---|---|---|---|
| 246-869 | Entire chapter | Pharmacy licensing--pharmacies and differential hours | 18.64.005 | Board of Pharmacy | HSQA | | |
| 246-870 | Entire chapter | Electronic transmission of prescription information | 69.41, 69.50 18.64.005. | Board of Pharmacy | HSQA | | |
| 246-871 | Entire chapter | Pharmaceutical--parenteral products for non-hospitalized patients | 18.64.005 | Board of Pharmacy | HSQA | | |
| 246-873 | Entire chapter | Pharmacy--hospital standards | 18.64.005, 18.64A | Board of Pharmacy | HSQA | | |
| 246-875 | Entire chapter | Pharmacy--patient medication record systems | 18.64.005, 18.64A | Board of Pharmacy | HSQA | | |
| 246-877 | Entire chapter | Pharmaceutical--sales prohibited | 18.64.005, 18.64A | Board of Pharmacy | HSQA | | |
| 246-878 | Entire chapter | Good compounding practices | 18.64.005, 18.64A | Board of Pharmacy | HSQA | | |
| 246-879 | Entire chapter | Pharmaceutical wholesalers--definitions | 18.64.005, 18.64A | Board of Pharmacy | HSQA | | |
| 246-881 | Entire chapter | Pharmacy--prescription drug price advertising | 18.64.005 | Board of Pharmacy | HSQA | | |
| 246-883 | Entire chapter | Pharmacy--identification of legend drugs | 18.64.005, 69.41.310 | Board of Pharmacy | HSQA | | |
| 246-885 | Entire chapter | Pharmacy--identification, imprints, markings, & labeling of legend drugs | 18.64.005 | Board of Pharmacy | HSQA | | |
| 246-886 | Entire chapter | Animal control--legend drugs | 18.64.005, 18.64A, 69.41.080 | Board of Pharmacy | HSQA | ✓ | |
| 246-887 | Entire chapter | Pharmacy-- uniform controlled substances act | 18.64, 18.64A, 69.50 | Board of Pharmacy | HSQA | ✓ | |
| 246-888 | Entire chapter | Medication assistance | 69.41; 18.64.005 | Board of Pharmacy | HSQA | | |
| 246-889 | Entire chapter | Pharmaceutical--precursor substance control | 18.65.005, 18.64.005, 69.43.050 | Board of Pharmacy | HSQA | | |
| 246-891 | Entire chapter | Pharmacy--prophylactics | 18.64.005 | Board of Pharmacy | HSQA | | |
| 246-895 | Entire chapter | Pharmacy--good manufacturing practice for finished pharmaceuticals | 18.64.005, 18.64A | Board of Pharmacy | HSQA | | |
| 246-897 | Entire chapter | Pharmacy drug availability | 18.64.005 & 18.64A | Board of Pharmacy | HSQA | | |
| 246-899 | Entire chapter | Pharmaceutical--drug product substitution | 18.64.005, 18.64A | Board of Pharmacy | HSQA | | |
| 246-901 | Entire chapter | Pharmacy assistants | 18.64.005, 18.64A | Board of Pharmacy | HSQA | | |
| 246-903 | Entire chapter | Nuclear pharmacies and pharmacists | 18.64.005 | Board of Pharmacy | HSQA | | |
| 246-904 | Entire chapter | Health care entities | 18.64.005 | Board of Pharmacy | HSQA | | |
| 246-905 | Entire chapter | Pharmacy--home dialysis program | 18.64.005, 18.64A | Board of Pharmacy | HSQA | | |
| 246-907 | Entire chapter | Pharmaceutical licensing periods and fees | 43.70.250, 43.70.040 | Secretary | HSQA | | |
| 246-915 | Entire chapter | Physical therapists | 18.74.023 | Physical Therapy Board | HSQA | | |
| 246-918 | Entire chapter | Physician assistants | 18.71.017, 18.71.050 | Medical Quality | HSQA | | |

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|---|---|---|---|---|---|---|---|
| | | | | Assurance Commission | | | |
| 246-919 | Entire chapter | Medical quality assurance commission | 18.71.017 | Medical Quality Assurance Commission | HSQA | | |
| 246-922 | 001 -032, 040 – 270, 300-500, 995 | Podiatric physicians and surgeons | 18.22.015, 18.130.040; 43.70.250 | Podiatry Board | HSQA | | |
| 246-922 | 033, 035, 275, 280 , 290, 295, 990 | Podiatric physicians and surgeons--eligibility for licensure, address notification, renewal expiration; inactive license & reactivation; lapsed license renewal; fees | 18.22.018; 18.22.015 18.130.040 | Podiatry Board/Secretary | HSQA | | |
| 246-924 | Entire chapter | Psychologists | 18.83.050 | Psychology Board | HSQA | | |
| 246-926 | Entire chapter | Radiological technologists | 18.84.040, .080, .100, .110; 18.130.070; 70.24.270 | Secretary | HSQA | | |
| 246-927 | Entire chapter | Recreation therapy | 18.230.040 | Secretary | HSQA | | |
| 246-928 | Entire chapter | Respiratory care practitioners--scope of practice | 18.89.040, 050; 43.70.040 18.130.050; .075, .097; 70.24.270, 43.70.040 | Secretary | HSQA | | |
| 246-930 | Entire chapter | Sex offender treatment provider | 18.155.040 | Secretary | HSQA | | |
| 246-933 | Entire chapter | Veterinarians | 18.92.030 | Board Of Veterinary Technology | HSQA | | |
| 246-935 | Entire chapter | Veterinary animal technicians | 18.92 | Board Of Veterinary Technology | HSQA | | |
| 246-937 | Entire chapter | Certified veterinary medication clerks | 18.92.030 18.92.145. | Board Of Veterinary Technology | HSQA | | |
| 246-939 | Entire chapter | Surgical technologist program | 18.215; 18.130.050. | Secretary | HSQA | | |
| 246-976 | Entire chapter | EMS & trauma care systems | 18.71, 18.73, 70.168 | Secretary | HSQA | | |